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No. 99-830

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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME III, PAGES 482 TO 731

DON STENBERG
Attorney General

L. STEVEN GRASZ
Deputy Attorney General
Counsel of Record
2115 State Capitol
Lincoln, Nebraska
68509-8920
(402) 471-2682

Counsel for Petitioners

SIMON HELLER
Counsel of Record
JANET BENSHOOF
PRISCILLA J. SMITH
SUZANNE NOVAK
THE CENTER FOR REPRODUCTIVE LAW & POLICY
120 Wall Street
New York, New York
10005
(212) 514-5534

JERRY M. HUG
ALAN G. STOLER
Historic Library Plaza
1823 Harney Street
Suite 1004
Omaha, Nebraska 68102
(402) 346-1733

Counsel for Respondent

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 7

AMERICAN MEDICAL ASSOCIATION'S "REPORT OF THE BOARD OF TRUSTEES ON LATE-TERM ABORTION"

* * *

PREVALENCE OF AND REASONS FOR INDUCED ABORTION

The Centers for Disease Control and Prevention (CDC) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."[24*] A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention are not regarded as an induced abortion.

The most scientifically reliable, national data on the incidence of abortion and characteristics of women who have abortions in the United States come from the Centers for Disease Control and Prevention and the Alan Guttmacher Institute (AGI). The Alan Guttmacher Institute is an independent, nonprofit corporation for research, policy analysis, and public education. Because the prevalence of late-term abortion procedures has been questioned in the popular press, it is worth describing the type of national abortion statistics which are collected in the United Statistics [sic] as well as methods of data collection.

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* Endnotes beginning with 24 are reprinted at page 498.

Both the CDC and the AGI collect data on the total number of abortions in the United States. The CDC data are derived primarily from reports by state health departments, whereas the AGI collects data directly from abortion providers. For many years AGI estimates of the number of abortions performed in the United States each year have been higher and considered to be more accurate than those reported by the CDC.[25, 26] However, AGI does not collect data on gestational age. Instead, it uses CDC data on the number of abortions performed at various gestational ages and makes statistical adjustments for discrepancies between AGI and CDC data when publishing its estimates.

Although the CDC collects annual data on abortion, the data have limitations. First, all states do not provide abortion-related information to the CDC. As recently as 1992, Alaska, California, Iowa, New Hampshire and Oklahoma did not collect data on abortion. For these states the CDC conducted limited surveys of abortion providers or estimated the number of abortions.[25-27] Second, information from state health departments on abortion is often incomplete, with some states lacking information on as many as 40% to 50% of the abortions performed in the states.[26, 27] Third, the categories used by the CDC to report the method of abortion differentiate between D&E, labor induction procedures, and hysterotomy/hysterectomy, but they do not have a separate category for D&X. Fourth, states vary in their method of recording gestational age. Some use the number of weeks since the first day of the woman's last menstrual period, and others record the physician's estimate of gestational age. Finally, although the CDC is the only organization

which collects national data on abortion by weeks of gestation, it does not provide a detailed breakdown of abortions performed at 21 weeks and beyond.

Despite these limitations, the CDC and AGI remain the most reliable sources of national data on abortions. As shown in table 1, the vast majority (95%) of induced abortions are done at or before 15 weeks' gestation, in the first or very early second-trimester.[27]

Table 1: Induced Abortion: 1992

Gestational Age	Number	Percent of procedures
≤ 8 weeks	798,850	52%
9-10 weeks	377,570	25%
11-12 weeks	181,960	12%
13-15 weeks	94,060	6%
16-20 weeks	60,040	4%
21 weeks or more	16,450	1%
TOTAL	1,528,930	100%

A more detailed, estimated breakdown of the number of induced abortions at 21 weeks or more appears in Table 2.[27] The estimate is based on data from the CDC abortion surveillance reports, data collected by the National Center for Health Statistics (NCHS) from 14 states, and AGI survey data; estimates were calculated by the AGI. However, these estimates must be viewed cautiously. First, they are based on a limited number of states which may not be representative of the nation as a whole, and reporting by these states may be incomplete. Second, assuming that the number of providers who perform late-term abortions is relatively small,[27] they may have relatively large caseloads. The number of late-term abortions would

be underestimated if these providers were not in the NCHS sample. Third, random errors in coding gestational age could substantially inflate the estimated number of abortions performed beyond 26 weeks, because these procedures constitute such a small proportion of abortions overall. Fourth, clinician errors in estimating gestational age could bias the data in unknown ways. Finally, natural fetal deaths beyond 20 weeks of gestation reported to the NCHS may be mistakenly counted as abortions if the fetus were removed using procedures commonly used to induce abortion.[27]

Table 2: Estimated Number of Late-Second- and Third-Trimester Induced Abortions

Gestational Age	Number	Percent of procedures at 21 weeks or later
21-22 weeks	10,340	63%
23-24 weeks	4,940	30%
25-26 weeks	850	5%
>26 weeks	320	2%
TOTAL	16,450	100%

According to these estimates, two-thirds of abortions beyond 20 weeks are performed between 21 and 22 weeks. After 26 weeks, the number of abortions nationwide is estimated as being between 320 and 600. While it is not possible to quantify the type of D&E procedure used in these circumstances, it is estimated that 86% of all abortions performed past 20 weeks of gestation are performed by dilation and evacuation (D&E), and most of the remainder by inducing labor.[27]

In 1992, teenagers were more likely than older women to have an abortion at 16 weeks of gestation or later.[25] Approximately 9% of women 19 years of age and younger who had an abortion in 1992, had the procedure performed at 13 weeks of gestation or later, compared to 5% of women 20 years of age and older.[25] Seven percent of women who were black or of other races who had an abortion in 1992 had the procedure performed during the second- or third-trimester, compared to 5% of white women. Differences between Hispanic and non-Hispanic women were minimal (6.5% and 6.3%, respectively).[25]

Little research has been done on reasons for induced abortion in the second-trimester. In 1987, AGI conducted a survey of patients in 30 abortion facilities in which at least 400 abortions were performed annually and which performed abortions at 16 or more weeks of gestation.[28] The 30 providers represented each of the four regions of the country and the average patient response rate was 80 percent. Of the 1,900 women in the survey, 420 had been pregnant for 16 or more weeks and they were asked to report the most important reasons for their delay in having an abortion. Seventy-one percent reported that they did not recognize that they were pregnant or misjudged gestation. Forty-eight percent reported having difficulty making arrangements for an abortion (particularly raising enough money for the procedure), 33% were afraid to tell their parents or partner, and 24% reported having had great difficulty with the decision to have an abortion. Women having a later abortion were more likely than other women to cite personal health problems, possible fetal health problems, or rape or incest as having caused the pregnancy.

Medical reasons for second-trimester abortions can include maternal indications, such as those which threaten her health or life. For some women the condition may have existed prior to the pregnancy, for others a condition may have occurred during the pregnancy, and for others, the condition could have resulted from the pregnancy itself.

Some serious fetal abnormalities are not diagnosed until the second-trimester and the discovery of such anomalies prompt some women to decide to terminate the pregnancy by inducing abortion. Amniocentesis is usually performed between the 14th and 18th weeks of pregnancy, and the results usually are not available for another two to three weeks. Chorionic villus sampling (CVS) can be performed earlier, between the 10th and 12th weeks of pregnancy. Preliminary results are usually available within 48 hours and confirmatory, final results typically take a maximum of 7 to 10 days. However, the timing of an induced abortion prompted by the discovery of fetal anomalies through CVS or amniocentesis is almost certain to occur after the first trimester.

PROCEDURES USED TO INDUCE ABORTION

The procedure used to induce abortion depends, in part, on gestational age, commonly defined as the number of weeks since the first day of the last menstrual period, based on a 28-day menstrual cycle.[29] The percentage of reported legal abortions by weeks of gestation and type of procedure appears in Table 3.[25] As can be seen, suction or sharp curettage and dilatation and evacuation are the most common procedures used to induce abortion in the

United States (99%). However, by 16 weeks of gestation and beyond, approximately 9% of induced abortions are performed using labor induction techniques. Hysterotomy and hysterectomy are used very rarely, regardless of gestational age.

Table 3: Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure – United States, 1992

	Weeks of gestation				
Type of procedure	<8-12 weeks	13-15 weeks	16-20 weeks	≥21 weeks	Total
Curettage (suction or sharp)[a]	99.9%	98.2%	86.0%	86.4%	99.0%
Labor induction[b]	0.0%[c]	1.0%	8.8%	9.1%	0.6%
Hysterotomy Hysterectomy	0.0%[c]	0.0%[c]	0.0%[c]	0.1%	0.0%[c]
Other[d]	0.09%	0.8%	5.1%	4.4%	0.4%
Total[e]	100%	100%	100%	100%	100%

[a]Includes dilatation and evacuation

[b]Includes intrauterine saline instillation and intrauterine prostaglandin instillation

[c]<0.05%

[d]Includes instillation procedures not reported as a specific category

[e]Reported by 35 states and New York City

First Trimester Procedures to Induce Abortion

Since the 1970s, vacuum aspiration, also referred to as suction curettage, has been the most common procedure used to induce abortion in the first trimester (i.e., from the 6th through 12th week of gestation).[25-26] Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator.[30] Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue.[30,31] These procedures are typically performed on an outpatient basis.

Menstrual regulation, also known as menstrual extraction, is a type of early suction currettage. After inserting the cannula, the clinician attaches the syringe, releases the pinch valve, and suctions blood and tissue into the syringe. The procedure can be performed no later than 42 to 50 days from the last menstrual period.[32] Neither anesthesia nor dilation are usually necessary.

In the last several years, pharmaceutical agents have also been used to induce abortion in the first trimester. These include mifepristone (RU-486), a synthetic hormone, which can be used within 9 weeks of the last menstrual period.[31] Mifepristone causes the lining of the uterus to shed by blocking progesterone, thereby terminating the

pregnancy. To induce abortion, the woman takes one oral does of mifepristone followed a few days later by misoprostol, to stimulate uterine contractions and expel the embryo.[31] Methotrexate used in conjunction with misoprostol represents a second pharmaceutical approach.[33]

Early-Second-trimester Procedures to Induce Abortion

During the second-trimester the most common procedure used to induce abortion is dilation and evacuation (also referred to [sic] dilatation and evacuation or D&E), which refers generically to transcervical procedures performed at 13 weeks gestation or later.[34-36] Labor induction techniques can also be used during the second-trimester though they are more common in the late-second and third-trimesters. These procedures are described below.

Dilation and evacuation procedures are usually performed early in the second-trimester, that is, in the 13th through 15th week of gestation.[25, 36] Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D&E procedure.[32, 37-39] D&E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators are usually used. Intraveous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to

ensure that no tissue remains. In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.[30-32]

Mid-Second-Trimester and Third-Trimester Procedures to Induce Abortion

By the 16th to 24th week of gestation there are several alternative procedures that can be used to induce abortion, though some are more common than others. These include dilation and evacuation (which may or may not be preceded by induced fetal demise), dilation and extraction (D&X), labor induction, hysterotomy and hysterectomy.

By the 16th week of gestation, ultrasonography should be used to verify gestational age. Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopression is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage.[32, 36] Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal

potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation.[30]

To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction (D&X). According to the American College of Obstetricians and Gynecologists, intact D&X is comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.[19] This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb.

As gestational age increases, particularly during the 16th to 24th week, labor induction techniques are more commonly used to induce abortion.[25] Labor induction techniques can be subdivided by the type of abortifacient used (hypertonic solutions such as urea or saline), and prostaglandin inductions (e.g., prostaglandin E_2 suppositories).[32, 39] The use of hypertonic solutions typically produce fetal death from osmotic insult, and labor then usually follows. In a saline abortion, a needle is inserted through the abdomen and the amniotic sac is injected with a concentrated salt solution. This results in fetal

demise and induces contractions of the uterus. Over several hours, the contractions cause the cervix to dilate and the contents of the uterus to be expelled. Alternatively, urea, a nitrogen-based solution that causes fetal demise when injected into the amniotic sac, typically is used in conjunction with subsequent administration of prostaglandins, to induce contractions of the uterus and to expel its contents.[31] Unlike saline instillation, the use of urea does not cause maceration of the fetal tissues and thereby interfere with the histologic diagnosis of some types of fetal abnormalities.[40]

Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion.[26, 34, 41, 42] Hysterotomy involves the surgical delivery of the fetus through an incision in the uterine wall and the abdomen. Anesthesia is administered through an epidural, a spinal, or through general anesthesia. After removing the fetus the umbilical cord is cut and placenta removed. Hysterotomy involves major surgery and must be done in a hospital setting. It typically lengthens a woman's hospital stay and recovery.[31] Hysterectomy is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix.[32]

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Maternal Mortality

Maternal mortality is the most serious complication resulting from induced abortion, and the risk of maternal death increases with gestational age. In 1991, the overall rate of maternal mortality was one per 167,000 abortions.[43] The risk of maternal death from induced abortion at 8 weeks gestation or less was one in 600,000 procedures, but by 16-20 weeks increased to one in 17,000 procedures. At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries, though the difference was not statistically significant.[43]

Maternal mortality rates comparing dilation and evacuation, labor induction, and hysterectomy/hysterotomy at 13 weeks gestation or later are shown in Table 4.[44] For all types of procedures maternal mortality rates increase with gestational age, but they are significantly greater for hysterectomy and hysterotomy, regardless of gestational age. Maternal mortality rates, overall, are higher for labor induction than D&E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D&E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3).

Table 4: Maternal Mortality Rates* for Induced Abortion Procedures at 13 Weeks' Gestation or Later, United States, 1974-1987

	Weeks of gestation			
Type of procedure	13-15 weeks	16-20 weeks	≥21 weeks	Total
Dilation and evacuation	2.0	6.5	11.9	3.7
Labor induction	3.8	7.9	10.3	7.1
Hysterectomy/ hysterotomy	28.1	103.4	274.3	51.6

*Per 100,000 abortions

Maternal Morbidity

It is difficult to estimate abortion-related morbidity because definitions of what constitutes a complication vary widely, and because in the United States national data on abortion-related morbidity have not been collected on a systematic, ongoing basis. The best available national data on complications was collected during the 1970s by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council (New York, NY) and the CDC.[45] JPSA consisted of three prospective studies of abortion between 1971 and 1978, and involved a sample of hospitals and clinics throughout the United States. Between 73,000 and 84,000 women were involved in each phase of the research program.

The most commonly used indicator of abortion-related morbidity is admission to a hospital. This excludes minor physical sequelae but captures fairly accurately the more

serious maternal aftereffects of induced abortion. The CDC defines major complications from induced abortion as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0°C (100.4°F) that lasts for 3 or more days.[46]

Between 1970 and 1990 the overall risk of major complications from abortion-related procedures declined dramatically. From 1970 to 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.[47] Between 1975 and 1978 the rate dropped to five major complications per 1000 abortions,[46] and by 1990, the National Abortion Federation (Washington, DC) estimated that there was one complication per 1000 abortions.[48] The overall decline in complication rates can probably be attributed to an increased proportion of procedures being performed earlier in the pregnancy, improvements in medical technology, and improvements in medical training.

The risk of complications is related to the abortion method used. Between 1975 and 1978, the last years of the Joint Program for the Study of Abortion, the complication rate associated with vacuum aspiration was two per 1000 procedures, while dilation and evacuation had a complication rate of seven per 1000 procedures. Procedures that induced labor (saline or prostaglandin instillation) had a higher rate (21 and 25 per 1000 procedures, respectively), and those involving major surgery had the highest rate of complications.[47]

The risk of complications and complication rates from induced abortion are also related to gestational age. From 1975 to 1978 there were between 1 and 4 major complications per 1000 procedures performed through the 12th week of gestation.[32] There were 6 major complications per 1000 procedures performed in weeks 13 to 14, 13 per 1000 in weeks 15 to 16, and 19 per 1000 in weeks 17 through 20.[32]

More recent, international data have also shown that complication rates increase with gestational age. Direct comparisons on abortion-related complication rates between countries must be made with caution because of differences in the definition and measurement of complications. Nonetheless data from 1988 for Denmark, West Germany, and New York state, and from 1987 for Canada, England and Wales, showed complication rates ranging from 0.4% to 3.4% for first-trimester abortions, and from 1.1% to 8.7% for second-trimester abortions.[49] However, more research on major complication rates associated with various procedures and by gestational age is needed before any firm conclusions about the relative safety of procedures can be made.

Cervical incompetence and compromised subsequent pregnancies are important but unresolved concerns related to abortions performed in the second- or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X), or from labor induction techniques. Some physicians prefer D&E over labor induction methods for second-trimeser abortions because, they argue, it has a lower mortality rate, it takes less time, it is less expensive, it can be done on an outpatient basis, and

it takes less of a psychological toll on some women because it does not imitate labor.[33, 50, 51] Other physicians prefer to induce labor because they find it a less distastefull procedure.[50] Still others prefer it because they feel that it is less likely to interfere with the diagnosis of cytogenetic, anatomical, or DNA abnormalities in the fetus, particularly if saline instillation is avoided.[52] However, one research study involving 60 patients who underwent D&E at 14-22 weeks of gestation after fetal abnormalities were detected, found that D&E successfully and consistently confirmed abnormal prenatal diagnoses.[40]

In summary, maternal mortality during second-trimester abortions is lower for dilation and evacuation procedures than for labor induction methods. However, for procedures performed at 20 weeks' gestation and beyond, the rates are similar. More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond.

* * *

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 9

NEBRASKA
1996
Statistical Report
of
Abortions

Nebraska Health & Human Services System
Department of Regulation and Licensure
Data Collection Section

Deb Thomas, Director
Department of Regulation & Licensure

Monica Seeland, R.R.A.
Section Administrator
Data Collection Section

Stanley S. Cooper, M.S., Ph.D.
Service Administrator
Vital Statistics

Mark Miller
Health Data Coordinator

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NEBRASKA ABORTIONS, 1996

This report presents tabulations of statistical information reported on records of induced abortions performed in Nebraska during 1996. These data are in compliance with specifications set forth in Nebraska Statute 28-325 - 28-347.

A total of 5,214 abortions were reported to the Nebraska Department of Health and Human Services during 1996, an increase of 7.8% when compared to the 1995 total of 4,838. The following chart shows the number of abortions performed; the percentage of abortions in different age groups; the mean and modal age of the patient; and the number of abortions per 1,000 live births since 1976.

Chart I:

Year	Total	19 and Under Percent	20-29 Percent	30 and Over Percent	Mean Age	Modal Age	Ratio*
1977	4,534	41.8	47.1	11.1	22.0	19	177.4
1978	4,838	42.1	46.5	11.4	22.0	19	190.3
1979	4,936	39.7	48.3	12.1	22.3	18	185.8
1980	6,060	34.8	52.4	12.8	22.7	19	219.0
1981	5,753	33.0	53.7	13.3	22.9	18	209.1
1982	5,698	31.8	55.0	13.2	23.0	19	209.2
1983	5,625	30.8	55.8	13.4	23.0	19	211.5
1984	5,995	30.1	55.2	14.6	23.2	20	226.7
1985	6,012	30.0	55.3	14.7	23.3	20	232.3
1986	5,761	30.2	53.5	16.3	23.4	19	232.7
1987	5,858	30.0	53.2	16.8	23.5	18	243.2
1988	6,006	29.3	52.8	17.9	23.8	19	247.5
1989	5,871	29.0	51.4	19.6	24.1	19	239.5
1990	6,346	28.6	52.1	19.4	23.9	19	257.7
1991	6,194	24.6	55.2	20.2	24.3	21	256.0
1992	5,637	22.7	56.6	20.7	24.5	21	238.4
1993	5,486	22.4	55.6	22.0	24.6	20	234.6
1994	5,324	22.1	55.0	22.8	24.7	22	229.2
1995	4,838	22.2	55.0	22.9	24.8	23	205.4
1996	5,214	22.3	54.5	23.2	24.9	19,22	222.0

*Abortions per 1,000 live births. The 1996 ratio is provisional.

Table 1: Number of Abortions by Month
Nebraska, 1996

Number by Month	
January	604
February	399
March	501
April	442
May	496
June	380
July	392
August	483
September	362
October	434
November	432
December	289
TOTAL	5,214
Average per Month:	435

Table 2: Number of Abortions by State of Residence
Nebraska, 1996

State of Residence	
Arizona	2
California	1
Colorado	3
Florida	2
Hawaii	1
Idaho	1
Illinois	2
Indiana	2
Iowa	766
Kansas	17
Kentucky	1
Michigan	1
Minnesota	7
Missouri	28

Nebraska	4,169
New Jersey	1
New York	1
North Carolina	1
North Dakota	1
Oklahoma	1
South Carolina	1
South Dakota	183
Tennessee	1
Texas	3
Wyoming	2
Canada	1
Unknown	15

Table 3: Number and Percent of Abortions by Age of Patient Nebraska, 1996

Age of Patient	Number	Percent
<15	25	0.5
15-19	1,138	21.8
20-24	1,749	33.5
25-29	1,087	20.8
30-34	659	12.6
35-39	424	8.1
40-44	115	2.2
>44	7	0.1
Unknown	10	0.2
TOTAL	5,214	100.0

Mean Age: 24.9 Median Age: 24.1 Modal Age: 19, 22

Please note: For the table Number and Percent of Abortions by Age of Patient, the percentage does not add to 100.0 because of rounding.

Table 4: Number and Percent of Total Abortions by Reason Nebraska, 1996

Reason for Abortion	Number	Percent of Total Abortions
Socio-Economic	2,879	55.2
Physical Health	38	0.7
Imminent Peril	2	0.0
Mental Health	644	12.4
Rape	3	0.1
Other	2,319	44.5
Unknown	816	15.7
TOTAL	6,701*	

* – These figures do not equal the total number of abortions due to the indication of multiple reasons on some reports.

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1996

Method	Number	Percent of Total Abortions
Suction Curettage	5,161	99.0
Sharp Curettage	550	10.5
Other	49	0.9
Unknown	4	0.1
TOTAL	5,764*	

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

Table 6: Number and Percent of Previous Abortions Nebraska, 1996

Previous Abortions	Number	Percent
0	3,139	60.2
1	1,282	24.6
2	445	8.5
3	165	3.2
4	79	1.5
>4	94	1.8
Unknown	10	0.2
TOTAL	5,214	100.0

Table 7: Number of Abortions by Number of Physicians Nebraska, 1996

Number of Abortions	Number of Physicians	Abortions Performed
<25	3	9
25-499	0	0
>499	5	5,205
TOTAL	8	5,214

Table 8: Previous Parity* by Age of Patient
Nebraska, 1996

		Number of Live Births							
Age	Total	0	1	2	3	4	5	6	≥6
TOTAL	5,214	2,520	1,222	865	392	140	49	18	8
12	1	1							
13	3	3							
14	21	21							
15	66	65	1						
16	159	150	9						
17	187	176	11						
18	350	300	47	3					
19	376	290	73	12	1				
20	354	226	97	24	5	2			
21	371	220	115	27	7	2			
22	376	214	114	34	10	4			
23	317	155	93	45	23		1		
24	331	137	98	70	20	4	1	1	
25	285	98	92	71	14	6	4		
26	236	99	66	42	21	7	1		
27	224	70	58	54	31	10	1		
28	172	40	49	48	24	9	2		
29	170	43	54	32	28	11	2		
30	161	35	38	49	23	8	3	4	1
31	132	35	27	42	21	3	2	1	1
32	140	28	30	50	17	9	1	3	2
33	117	21	27	38	17	7	3	3	1
34	109	16	23	39	16	11	4		
35	108	18	28	32	21	6	2		1
36	109	19	19	39	19	7	4	1	1
37	73	12	12	21	16	7	5		
38	67	6	9	25	16	8	1	2	
39	67	8	9	24	15	7	3	1	
40	49	5	9	19	10	4	1		1
41	32		3	13	9	2	3	2	
42	14		3	5	2	2	2		
43	10	2	2	3	2		1		
44	10	1	2	1	3	2	1		
45	1						1		
46	5	1	1	2	1				
49	1					1			
Unknown	10	5	3	1		1			

* - Number of live births previous to this abortion.

Table 9: Gravidity* by Age of Patient
Nebraska, 1996

Age	Total	Number of Pregnancies								
		1	2	3	4	5	6	7	8	≥8
TOTAL	5,214	1,685	1,142	882	603	395	198	129	70	110
12	1	1								
13	3	3								
14	21	21								
15	66	59	7							
16	159	131	26	2						
17	187	148	30	8	1					
18	350	229	98	17	5	1				
19	376	214	102	44	10	5	1			
20	354	154	109	54	23	7	3	4		
21	371	145	109	71	32	11	1	1		1
22	376	136	114	76	27	15	4	3		1
23	317	89	87	64	44	10	11	5	6	1
24	331	80	82	65	54	23	9	6	7	5
25	285	53	70	77	36	21	13	5	3	7
26	236	53	51	45	40	25	7	5	4	6
27	224	37	45	41	41	24	21	7	2	6
28	172	22	36	34	28	30	11	3	4	4
29	170	18	32	35	22	29	16	13	1	4
30	161	20	23	27	27	29	10	10	7	8
31	132	16	16	28	27	22	10	2	4	7
32	140	11	20	26	26	23	7	9	6	12
33	117	10	13	23	23	15	11	7	6	9
34	109	5	9	29	19	16	12	8	6	5
35	108	5	15	32	18	16	7	5	3	7
36	109	9	12	20	18	15	11	13	4	7
37	73	5	11	14	15	10	4	6	2	6
38	67	2	6	9	25	12	6	5	1	1
39	67	2	4	14	15	15	3	5	2	7
40	49	1	6	10	11	10	7	1	1	2
41	32		1	6	9	3	7	3	1	2
42	14		1	4	2	2	4	1		
43	10	1	2	3	2	1		1		
44	10	1		3		2	2	1		1
45	1									1
46	5		2	1	1	1				
49	1					1				
Unknown	10	4	3		2	1				

* - Total pregnancies, including this abortion and all previous live births, still births, and abortions.

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1995

Method	Number	Percent of Total Abortions
Suction Curettage	4,831	99.9
Sharp Curettage	380	7.9
Other	5	0.1
Unknown	2	0.0
TOTAL	5,218*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1995

Number of Abortions	Number of Physicians	Abortions Performed
<25	6	25
25-499	2	450
>499	3	4,363
TOTAL	11	4,838

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1994

Method	Number	Percent of Total Abortions
Suction Curettage	5,306	99.7
Sharp Curettage	304	5.7
Other	8	0.2
Unknown	11	0.2
TOTAL	5,629*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1994

Number of Abortions	Number of Physicians	Abortions Performed
<25	8	30
25-499	1	490
>499	3	4,796
Unknown		8
TOTAL	12	5,324

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1993

Method	Number	Percent of Total Abortions
Suction Curettage	5,480	99.9
Sharp Curettage	2	0.0
Other	3	0.1
Unknown	2	0.0
TOTAL	5,487*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1993

Number of Abortions	Number of Physicians	Abortions Performed
<25	5	21
25-499	2	425
>499	3	5,031
Unknown		9
TOTAL	10	5,486

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1992

Method	Number	Percent of Total Abortions
Suction Curettage	5,625	99.8
Sharp Curettage	5	0.1
Intra-uterine prostaglandin instillation	3	0.1
Hysterotomy	0	–
Hysterectomy	1	0.0
Other	3	0.1
Unknown	6	0.1
TOTAL	5,643*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1992

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	60
25-499	1	36
>499	4	5,482
Unknown		59
TOTAL	15	5,637

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1991

Method	Number	Percent of Total Abortions
Suction Curettage	6,147	99.2
Sharp Curettage	2	0.0
Hysterotomy	0	–
Hysterectomy	0	–
Other	37	0.6
Unknown	9	0.1
TOTAL	6,195*	

* – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1991

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	12	56
25-499	0	0
>499	3	6,138
TOTAL	15	6,194

* * *

NEBRASKA ABORTIONS

1990

* * *

Method	Number	Percent
Suction Curettage	6,254	98.5
Sharp Curettage	2	0.0
Hysterotomy	1	0.0
Hysterectomy	22	0.3
Other	13	0.2
Unknown	56	0.9
TOTAL	6,348**	100.0*

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	14	58
25-499	0	0
>499	3	6,288
TOTAL	17	6,346

* – Does not equal 100.0 due to rounding.

** – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1989

* * *

Method	Number	Percent
Suction Curettage	5,862	99.7
Sharp Curettage	6	0.1
Other	1	0.0
Unknown	8	0.1
TOTAL	5,877**	100.0*

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	13	50
25-499	0	0
>499	3	5,821
TOTAL	16	5,871

* – Does not equal 100.0 due to rounding.

** – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1988

* * *

Method	Number	Percent
Suction Curettage	5,992	99.7
Sharp Curettage	6	0.1
Other	4	0.1
Unknown	11	0.2
TOTAL	6,013*	100.0**

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	9	29
25-49	0	0
50-99	0	0
100-499	2	635
>499	3	5,342
TOTAL	14	6,006

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

**Does not equal 100.0 due to rounding.

* * *

NEBRASKA ABORTIONS

1987

* * *

Method	Number	Percent
Suction Curettage	5,849	99.8
Sharp Curettage	2	0.0
Other	4	0.1
Unknown	6	0.1
TOTAL	5,861*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	42
25-49	0	0
50-99	0	0
100-499	1	214
>499	3	5,602
TOTAL	14	5,858

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1986

* * *

Method	Number	Percent
Suction Curettage	5,757	99.9
Sharp Curettage	2	0.0
Hysterotomy	1	0.0
Unknown	3	0.1
TOTAL	5,763*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	34
25-49	0	0
50-99	0	0
100-499	1	199
>499	4	5,528
TOTAL	15	5,761

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1985

* * *

Method	Number	Percent
Suction Curettage	6,009	99.8
Sharp Curettage	9	0.1
Unknown	2	0.0
TOTAL	6,020*	99.9**

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	11	46
25-49	0	0
50-99	0	0
100-499	2	386
500 +	3	5,580
TOTAL	16	6,012

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

**Does not equal 100.0 due to rounding.

* * *

NEBRASKA ABORTIONS

1984

* * *

Method	Number	Percent
Suction Curettage	5,992	99.7%
Sharp Curettage	12	0.2
Hysterectomy	1	0.0
Unknown	1	0.0
TOTAL	6,009*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	15	69
25-49	0	0
50-99	1	64
100-499	1	215
500 +	3	5,647
TOTAL	20	5,995

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1983

* * *

Method	Number	Per Cent
Suction Curettage	5,592	99.1%
Sharp Curettage	21	0.4
Intra-Uterine Saline Instillation	1	0.0
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterotomy	2	0.0
Other	23	0.4
Unknown	3	0.1
TOTAL	5,643*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	21	93
25-49	0	0
50-99	0	0
100-499	1	200
500 +	3	5,332
TOTAL	25	5,625

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1982

* * *

Method	Number	Per Cent
Suction Curettage	5,689	99.6%
Sharp Curettage	18	0.3
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	1	0.0
Unknown	4	0.1
TOTAL	5,713*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	14	75
25-49	1	25
50-99	0	0
100-499	1	219
500 +	3	5,379
TOTAL	19	5,698

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1981

* * *

Method	Number	Per Cent
Suction Curettage	5,742	99.2%
Sharp Curettage	39	0.7
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	2	0.0
Other	3	0.0
Unknown	2	0.0
TOTAL	5,789*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	21	85
25-49	0	0
50-99	0	0
100-499	1	137
500 +	3	5,531
TOTAL	25	5,753

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1980

* * *

Method	Number	Per Cent
Suction Curettage	6,050	99.1%
Sharp Curettage	52	0.9
Intra-Uterine Saline Instillation	1	0.0
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	2	0.0
Unknown	2	0.0
TOTAL	6,108*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
≤24	19	113
25-49	1	29
50-99	0	0
100-499	1	111
≥500	3	5,807
TOTAL	24	6,060

*These figures do not equal the total number of abortions because some reports indicate more than one reason or method.

* * *

ABORTIONS

1979

* * *

Method	Number	Per Cent
Suction Curettage	4,836	95.7
Sharp Curettage	123	2.4
Intra-Uterine Saline Instillation	84	1.7
Hysterotomy	2	0.0
Other	6	0.1
Unknown	2	0.0
TOTAL	5,053*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
≤24	24	116
25-49	0	0
50-99	0	0
100-499	0	0
≥500	3	4,820
TOTAL	27	4,936

*These figures do not equal the total number of abortions because some reports indicate more than one reason or method.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 11

[SEAL]

STATE OF NEBRASKA

United States of America,)
) ss.
State of Nebraska)

Department of State

I, Scott Moore, Secretary of State of the State of Nebraska do hereby certify that

TITLE 174 – Nebraska Administrative Code – Chapter 8 – Form 1 – Records Management Service Report of Induced Abortion; and Form 2 – Certificate of Fetal Death – as adopted by the Nebraska State Health Department – Bureau of Vital Statistics were last partially amended and filed in the Office of the Secretary of State on December 17, 1996.

I further certify that there have been no amendments nor changes to the above mentioned Rules and Regulations since the above amendment date and have been in full force and effect through and including the current date of certification.

Finally I hereby certify that said Rules and Regulations were approved in the offices of the ATTORNEY GENERAL and the GOVERNOR of the State of Nebraska.

In Testimony whereof,

[SEAL]

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska.

Done at Lincoln this Tenth day of July in the year of our Lord, one thousand nine hundred and Ninety Seven

/s/ Scott Moore
SECRETARY OF STATE

STATE OF NEBRASKA DEPARTMENT OF HEALTH

Records Management Service
Report of Induced Abortion

FILED
DEC 17 1996

(Please print or type)

(State file number)

1. Name of Facility

Facility Address

Date of Abortion performed
Month Year

2. Facility chart case no.

4. Patient's legal residence
(State) (County - Optional)

5. Age last birthday

6. Marital status: ☐ Never married ☐ Widowed ☐ Separated ☐ Now married ☐ Divorced ☐ Unknown

7. Race: American Indian, Black, White, Asian/Pacific Islander, Other (specify) _____

Ancestry: Specify _____
Examples: French, Filipino, a Native American Tribe, English, Hispanic (such as Cuban, Mexican, or Puerto Rican), German, etc.

8. Education (check the highest grade or level completed)

None: 0 ☐
elementary or secondary: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐
college: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐

9. Previous pregnancies, abortions, and live births. (Complete all four sections; enter number or check none)

Live Births		Other Terminations
a. Now living Number _____ None ☐	b. Now dead Number _____ None ☐	c. Spontaneous abortions, miscarriages, stillbirths, and fetal deaths Number _____ None ☐

10. Clinical estimate of gestation
_____ (weeks)

11. Length of fetus _____ inches
not measurable ☐

12. Check the stated reason(s) for abortion:

- ☐ Maternal physical health
- ☐ Mental health
- ☐ Maternal life endangered
- ☐ Fetal abnormality
- ☐ Socio-economic
- ☐ Sexual assault
- ☐ [illegible]
- ☐ Contraceptive failure
- ☐ [illegible]

14. Type of procedure performed
Check one

1. ☐ Suction curettage
2. ☐ Medical induced
3. ☐ Dilation and evacuation
4. ☐ Sharp curettage
5. ☐ Dilation and [illegible]
6. ☐ Other

16. Did [illegible]
Yes ☐

17. Name of attending physician (type/print)

18. Initial of person completing report and phone number: (type/print)

19. Attending physician's signature

APPROVED
1-017-96

APPROVED
JOHN P. LEE
ATTORNEY GENERAL
NOV 27 1996

To be reported within fifteen (15) days of the end of the calendar month in which the abortion was performed.

Mail to: Records Management Service
P.O. Box 95065
Lincoln, NE 68509-5065

**Shaded areas are required by law.
See back for explanation.

RV Lynn A. Nelson -revised 10/08/96-

530

BEST AVAILABLE COPY

BUREAU OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

PERSONAL DATA

CAUSE

CERTIFIER

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

APPROVED

JAN 13 1992

APPROVED

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JAN 13 1992

1991

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 12

Bureau of Vital Statistics

REPORT OF INDUCED TERMINATION OF PREGNANCY

FACILITY—LOCATION (Street Address)	CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	COUNTY OF PREGNANCY TERMINATION
1a.	1b.	1c.

AGE OF PATIENT	RESIDENCE-STATE	PREVIOUS PREGNANCIES (Complete each section)			
		LIVE BIRTHS		OTHER TERMINATIONS	
		How living Number ____ None ☐	How dead Number ____ None ☐	Spontaneous Number ____ None ☐	Induced Number ____ None ☐
2.	3.	4a.	4b.	4c.	4d.

LENGTH OF FETUS	WEIGHT OF FETUS
5. _____ (not measurable) ☐	6. _____ (not measurable) ☐

7. REASON(S) ABORTION REQUESTED

☐ Socio-Economic ☐ Imminent Peril to Woman's Life or Health
☐ Physical Health ☐ Mental Health
☐ Other (Specify) _____

8a. PROCEDURE THAT TERMINATED PREGNANCY (Check only one)	TYPE OF TERMINATION PROCEDURES	8b. ADDITIONAL PROCEDURE USED FOR THIS TERMINATION, IF ANY (Check all that apply)
☐	SUCTION CURRETTAGE	☐
☐	SHARP CURRETAGE	☐
☐	INTRA-UTERINE SALINE INSTILLATION	☐
☐	INTRA—UTERINE PROSTAGLANDIN INSTILLATION	☐
☐	HYSTEROTOMY	☐
☐	HYSTERECTOMY	☐
☐	OTHER (Specify) _____	☐

9. COMPLICATIONS OF PREGNANCY TERMINATION

(Check all that apply)
☐ NONE
☐ HEMORRHAGE
☐ INFECTION
☐ UTERINE PERFORATION
☐ CERVICAL LACERATION
☐ RETAINED PRODUCTS
☐ OTHER (Specify) _____

10. DID AN EMERGENCY SITUATION CAUSE THE PHYSICIAN TO WAIVE ANY OF THE REQUIREMENTS OF SECTION 28-327
Yes ☐ No ☐

11a. Attending Physician _____
(Signature)

11b. Attending Physician _____
(Print or type name and address)

Mail to: Bureau of Vital Statistics
301 Centennial Mall South
P. O. Box 95007
Lincoln, Nebraska 68509—5007

To be mailed within fifteen days after each reporting month.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEBRASKA
[Caption Omitted In Printing]

EXHIBIT 17

TABLE 16. Reported legal abortions, by weeks of gestation and type of procedure* – United States, 1992

	Weeks of gestation													
	≤8		9-10		11-12		13-15		16-20		≥21		Total	
Type of procedure	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Curettage (suction or sharp)†	362,453	99.9	166,815	99.9	82,911	99.6	40,740	98.2	25,180	86.0	8,505	86.4	686,604	99.0
Intrauterine saline instillation	43	0.0§	32	0.0§	53	0.1	200	0.5	1,324	4.5	422	4.3	2,074	0.3
Intrauterine prostaglandin instillation	22	0.0§	19	0.0§	36	0.0§	199	0.5	1,273	4.3	469	4.8	2,018	0.3
Hysterotomy/ Hysterectomy	11	0.0§	7	0.0§	3	0.0§	3	0.0§	11	0.0§	6	0.1	41	0.0§
Other¶	282	0.1	70	0.0§	211	0.3	325	0.8	1,495	5.1	437	4.4	2,820	0.4
Total**	362,811	100.0	166,943	100.0	83,214	100.0	41,467	100.0	29,283	100.0	9,839	100.0	693,557	100.0

* Excludes unknowns.
† Includes dilatation and evacuation.
§ ≤0.05%.
¶ Includes instillation procedures not reported as a specific category.
** Reported by 35 states and New York City.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 20

STATE OF NEBRASKA
[SEAL] **Office of the Attorney General**
2115 STATE CAPITOL BUILDING
LINCOLN, NEBRASKA 68509-8920
(402) 471-2682
TDD (402) 471-2682
CAPITOL FAX (402) 471-3297
1235 K ST. FAX (402) 471-4725

DON STENBERG
ATTORNEY GENERAL

STEVE GRASZ
LAURIE SMITH CAMP
DEPUTY ATTORNEYS GENERAL

November 22, 1995

Leroy H. Carhart, M.D.
Abortion and Contraception
Clinic of Nebraska
1002 W. Mission Avenue
Bellevue, NE 68005

RE: Advertisement for Potentially Illegal Abortions

Dear Dr. Carhart:

It has come to our attention that your "yellow page" advertisements from the current Omaha and Lincoln telephone directories both advertise that your clinic performs "pregnancy termination through the 24th week."

In *Roe v. Wade* the United States Supreme Court recognized that states have a compelling interest in the life of a viable fetus. In fact, after viability the State's interests in preserving the life of the child are so strong that the

State may outlaw abortion so long as the law provides an exception to preserve the life and health of the mother. *See Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992). The State of Nebraska has, in fact, made it a felony to perform an abortion after viability. Neb. Rev. Stat. § 28-329 (1989).

Viability may not be determined according to some arbitrary schedule (i.e. 24 weeks), especially in light of ever-improving medical technology. In Nebraska, viability is defined as that stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb of the mother by natural or artificial means. Neb. Rev. Stat. § 28-326.

The U.S. Supreme Court has upheld mandatory viability testing at *20 weeks. Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3057 (1989) (note: this was six years ago). According to the Nebraska Department of Health, at 24 weeks (the age advertised by your clinic) the chance of survival outside the womb is 80 percent! (The state of Pennsylvania reports the survival rate is 82 percent). Again, abortions are *illegal* in Nebraska after the time at which the child can live even "more than momentarily" by natural or artificial means unless necessary to save the life or health of the mother.

In light of your public advertisement of "pregnancy termination through the 24th week", you are requested to respond to the following questions:

1). Does your clinic perform abortions after the stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb of the mother by natural or artificial means?

2). If so, are these abortions limited to instances where it is necessary to preserve the life or health of the mother?

3). Do you consider all abortions necessary to preserve the health of a woman who desires an abortion? If not, which abortions are not necessary to preserve the health of the mother?

4). If your clinic only performs abortions after viability when necessary to preserve the life or health of the mother, why do your advertisements state that pregnancy termination is available "through 24th week" without restriction?

Please respond to this office within 30 day [sic] of your receipt of this letter. If you have questions regarding Nebraska law on this subject, you are advised to consult your attorney.

Sincerely yours,

DON STENBERG
Attorney General
/s/ Steve Grasz
Steve Grasz
Deputy Attorney General

Enclosures

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 21

STATE OF NEBRASKA

DEPARTMENT OF HEALTH
Mark B. Horton, M.D., M.S.P.H.
Director

[SEAL]
E. Benjamin Nelson
Governor

October 9, 1996

Mr. Simon Heller
Center for Reproductive
Law and Policy
120 Wall Street
New York, New York 10005

Dear Mr. Heller:

I will look forward to meeting with you and Dr. Leroy Carhart at 10:00 P.M. on Wednesday, October 16, 1996. Please notify me of the location for the interview as soon as arrangements have been made.

Regulatory Compliance investigations has a total of four unresolved case files pertaining to Dr. Carhart's practice. Questions regarding the complaints and issues surrounding these cases will include but may not be limited to the following areas.

1. Questions regarding the number of abortions performed weekly by Dr. Carhart in his last three practice

sites in the Bellevue, Nebraska area, prior to Dr. Carhart receiving a clinic license from the Nebraska Department of Health.

2. Questions regarding Dr. Carhart's administration and dispensing of controlled and non-controlled substances from his last three practice sites, pursuant to his Nebraska Controlled Substance Registration and pharmacy permit, to include questions regarding his record keeping practices involving controlled substances.

3. Questions regarding the physical conditions of Dr. Carhart's office at 1309 Harlan Drive in Bellevue, NE where Dr. Carhart was performing abortions.

4. Questions regarding the sterilization techniques used to process instruments in Dr. Carhart's various locations.

5. Questions regarding the disposal of fetal material following abortion procedures.

6. Questions regarding the nature of services provided by those who assist Dr. Carhart in abortions and questions regarding credentials and/or licensing of those individuals.

7. Questions regarding supervision of physician assistants and monitoring of physician assistant practice and charting.

8. Questions regarding the alleged modification by Dr. Carhart of employment time cards and an employment contract for work done by a physician's assistant formerly employed by Dr. Carhart.

9. Questions regarding the criteria for doing PAP smears and throat cultures on Medicaid patients.

10. Questions regarding the type of abortion procedures Dr. Carhart does at different stages of fetal development.

11. Questions regarding how Dr. Carhart determines fetal viability and an allegation he performs abortions on viable fetuses.

12. Questions regarding placement of Yellow Pages advertising abortions by or on behalf of Dr. Carhart.

13. Questions regarding medical coverage for post abortion patients of Dr. Carhart.

I would expect that my interview may last for approximately 2 to 3 hours. I hope this information will be of value to you. Please do not hesitate to contact me if you require additional information.

Sincerely,

/s/ Duane P. Newland
Duane P. Newland
Investigator
Regulatory Compliance
Investigations
P.O. Box 95164
Lincoln, NE 68509-5164
(402) 471-0175

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 22

(SEAL) STATE OF NEBRASKA

Office of the Attorney General
2115 STATE CAPITOL BUILDING
LINCOLN, NE 68509-8920
(402) 471-2682
TDD (402) 471-2682
CAPITOL FAX (402) 471-3297
1235 K ST. FAX (402) 471-4725

DON STENBERG
ATTORNEY GENERAL

STEVE GRASZ
LAURIE SMITH CAMP
DEPUTY ATTORNEYS
GENERAL

DATE: May 29, 1996

SUBJECT: Constitutionality of a statutory ban on "partial-birth" abortions in Nebraska

REQUESTED BY: Senator Jim Jensen

WRITTEN BY: Don Stenberg, Attorney General
Steve Grasz, Deputy Attorney General

You have requested an Attorney General's opinion as to "whether a ban on partial-birth abortions in the State of Nebraska would be constitutional."

I. Applicable Law

In *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705 (1973), the United States Supreme Court declared that "the unborn"

are not persons, and announced a new fundamental constitutional right to abortion which prevents States from outlawing abortion before viability of the child. 410 U.S. at 147-165, 93 S.Ct. at 724-733. *Roe* established a "trimester" framework governing state regulation of abortion. Under *Roe*, virtually no restrictions could be placed on first trimester abortions. After viability, though, the States could outlaw abortion except where necessary to preserve the life or "health" of the mother. *Id.* at 163-165, 93 S.Ct. at 732-733. The actual ability of States to prohibit abortions after viability was illusory, however, since the "health" exception swallowed the rule. In the companion case of *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739 (1973), the court defined "health" as including psychological, emotional, and familial factors (such as depression, youth, anxiety) as well as physical factors. *Id.* at 192, 93 S.Ct. at 747. Consequently, for all practical purposes, the termination of all pregnancies was a legally protected constitutional right for virtually any reason up until the birth of the child. In fact, in *Schulte v. Douglas*, 567 F.Supp. 522 (D.Neb. 1981), aff'd per curiam sub nom. *Womens Services, P.C. v. Douglas*, 710 F.2d 465 (8th Cir. 1983), the Federal District Court for the District of Nebraska invalidated a Nebraska statute which attempted to prohibit abortion after viability of the child even though the statute allowed postviability abortions that were "necessary to preserve the woman from an imminent peril that substantially endangers her life and health."

Although *Roe v. Wade* has never been overruled, in 1992 the U.S. Supreme Court discarded its arbitrary "trimester" framework, and placed greater emphasis on the States' interest in "potential" life throughout pregnancy.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791 (1992), the Court held that States could regulate pre-viability abortions as long as the regulation did not impose an "undue burden" on the woman. A state statute regulating abortion must have neither "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Planned Parenthood v. Casey*, 112 S.Ct. at 2820-21. *Casey* also lowered the judicial standard applied to state abortion statutes. "After *Casey*, the State need only show that it has a legitimate interest, and that the challenged regulation 'cannot be said [to] serve no purpose other than to make abortions more difficult.' " *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051, 1074 n.30 (S.D. Ohio 1995).

The Court clearly stated in *Casey* that after the unborn child reaches viability the State's interest in protecting the fetus outweighs the woman's liberty interest in having an abortion, subject only to a medical determination that an abortion is necessary for the preservation of the life or health of the mother. 112 S.Ct. at 2816-17, 2819-2821. Consequently, "regulations which apply only to post-viability abortions are presumptively valid, unless they have an adverse impact on the life or health of the pregnant woman." *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. at 1060.

Most significantly perhaps, the Court in *Casey* upheld a definition of "medical emergency" in a Pennsylvania statute which limited the physician's determination to consideration of *physical* health factors. 112 S.Ct. at 2822. The Supreme Court further stated, albeit in dicta, that it is only in "rare circumstances in which the pregnancy is

itself a danger to [the woman's] own life or health." 112 S.Ct. at 2806. If the Supreme Court meant what it said in *Casey*, then laws prohibiting post-viability abortions except where necessary to preserve the life and physical health of the mother are constitutional. If on the other hand, "health" is still an all-inclusive term, the Supreme Court's statements are mere legal sophistry, serving only to obscure the fact that babies' brains may still legally be suctioned out of their heads (as in partial-birth abortions) for virtually any reason. In fact, a federal district court recently held that "a state may not constitutionally limit the provision of abortion only to those situations in which a pregnant woman's physical health is threatened, because this impermissibly limits the physician's discretion to determine what measures are necessary to preserve her health." *Women's Medical*, 911 F.Supp. at 1081. Consequently, it is not clear whether "health" may be limited to physical factors. If not, the ability of States to proscribe abortions even after viability remains as illusory today as it was between 1973 and 1992. Nonetheless, the State of Nebraska is legally entitled to rely on the *Casey* decision until and unless a court of competent jurisdiction directs otherwise.

In sum, a total ban on "partial-birth abortions", especially since it would encompass both pre-viability and post-viability abortions, would likely have to pass the "undue burden" test of *Casey*.[1] Under *Casey*, "a state may

[1] Some legal scholars have argued that a less stringent test should be applied by reviewing courts due to the distinguishable features of a partial-birth abortion ban as compared to other abortion restrictions considered by the U.S.

act to prohibit a method of abortion, if there are safe and available alternatives." *Women's Medical*, 911 F.Supp. at 1067. In *Women's Medical*, the court framed the issue as "whether . . . there are safe and available alternatives to the D & X procedure, which is typically performed during the twentieth to twenty-fourth weeks of pregnancy, such that there would be no undue burden if the procedure were banned." *Id.*[2]

Supreme Court. *See* Hearings on HR 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. (Nov. 17, 1995) (testimony of David M. Smolin, Prof. of Law, Cumberland Law School, Samford University) transcript at pp. 344-350; Hearings on HR 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. (Nov. 17, 1995) (testimony of Douglas W. Kmiec, Prof. of Constitutional Law, University of Notre Dame), transcript at pp. 172-187 These arguments appear to have merit, and would likely be pursued in any litigation arising as a result of adoption of legislation banning partial-birth abortions. However, for purposes of this opinion, we will proceed under the most restrictive possible constitutional test.

[2] This opinion expresses no view as to the proper judicial standard for adjudicating a "facial" challenge to the constitutionality of an abortion statute, as opposed to a challenge to a statute "as applied". Since *Casey*, a split has developed among the circuit courts as to whether the approach taken in *Casey* has replaced the standard in *United States v. Salerno*, 481 U.S. 739 (1987). The Eighth Circuit has concluded that *Casey* did replace *Salerno*. *See Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1458 (8th Circuit 1995). However, in separate (and unusual) memoranda accompanying an order denying a writ of certiorari in this same South Dakota case, two Justices of the Supreme Court took differing views of this issue. Justice Scalia stated that this question "virtually cries out for our review." *Janklow v. Planned Parenthood*, 1996 WL 203346 (U.S.) (Scalia, J., dissenting) (April 29, 1996). It is possible, therefore, this issue will eventually be taken up by the Court in

II. Analysis

Because the answer to your question ultimately hinges on medical facts (i.e. whether there are "safe" and available alternatives to the partial-birth or D & X abortion procedure), it is essential to define the procedure and its alternatives. This opinion will not attempt to define all the available alternatives, but will discuss several relevant procedures.

A. Definition of Abortion Procedures

1. Partial-birth/D & X Abortions

The procedure referred to in your request ("partial-birth abortion") is also sometimes known as a "Dilation and Extraction". ("D & X") abortion. *See Women's Medical*, 911 F.Supp. at 1063; *Family Planning Specialists v. Powers*, 46 Cal.Rptr.2d 667, 668 (Cal.App. 1995). This procedure involves partial dilation of the woman's cervix; pulling the baby's feet and entire body out through the birth canal up to the baby's neck; piercing the baby's skull with a sharp instrument; insertion of a tube into the brain; removal of the brain by suction; collapse of the skull; and removal of head. The baby (usually 20-24 weeks old) may or may not be alive and kicking at the time his or her skull is pierced and brains are suctioned out.[3]

Women's Medical Professional Corp. v. Voinovich, 911 F.Supp. 1051 (S.D. Ohio 1995) (currently on appeal to the 6th Circuit), in which this issue was also litigated.

[3] Allegedly, some abortionists kill the baby by other means before the brain is removed. For example, one doctor says he cuts the baby's umbilical cord, and the baby dies before the procedure is performed. It reportedly "takes eight to ten minutes for the fetus to die, following the cutting of the umbilical cord." *Women's Medical*, 911 F.Supp. at 1066 n. 17. However, the same doctor told the American Medical News that two-thirds of the fetuses are alive when he performs the procedure. *See* Hearings on H.R. 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. Transcript at p. 23.

a. Haskell D & X

The best-known practitioner of this procedure is Dr. Martin Haskell. His D & X abortion procedure has been described as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultrasound, Haskell inserts forceps into the uterus, grasps a lower extremity [foot and leg], and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity [foot and leg], the torso, shoulders, and the upper extremities [arms]. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents [brain]. With the head decompressed, he then removes the fetus completely from the patient.

Women's Medical, 911 F.Supp. at 1066 (bracketed material added). Dr. Haskell has stated that about 80% of the D &

X abortions he performs between 20 and 24 weeks "are purely elective." *See* Hearings on H.R. 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess (Nov. 17, 1995) Transcript at p.13.[4]

b. Ohio Statutory Definition

In the State of Ohio, Dilation and Extraction abortion (D & X or partial-birth abortion) has been statutorily defined at follows:

> [T]he termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. 'Dilation and extraction procedure' does not include either the suction curettage procedure of abortion or the suction aspiration procedure of abortion.

O.R.C. § 2919.15(A) (The Ohio statute bans this procedure except where "all other available abortion procedures would pose a greater risk to the health of the pregnant women.").

c. Congressional Definition

The United States Congress defined partial-birth abortion as follows:

---

[4] We note that recent media reports in Nebraska concerning this procedure have not always described partial-birth abortions accurately. Several articles have stated that "the physician uses an instrument to pierce and drain the skull." The skull is not "drained". Rather, the brains are suctioned out. Use of the word "drained" is a factually inaccurate euphemism. The scientific reality is that the fetus or unborn child's brains are sucked out during what would otherwise constitute delivery.

> "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery. The Congressional bill excepted partial-birth abortions "necessary to save the life of a mother whose life is endangered by a physical disorder, illness or injury: Provided, that no other medical procedure would suffice for that purpose.

Partial Birth Abortion Ban Act of 1995 (H.R. 1833, as amended by the Senate Amendments. Congressional Record H 11604 (Nov. 1, 1995) and H 2905 (March 27, 1996)). *See also Sabelko v. City of Phoenix*, 68 F.3d 1169, 1174 n.1 (referencing Senate debate) ("the abortionist takes a pair of scissors and inserts the scissors into the back of the skull and then opens the scissors up to make a gap in the back of the skull in order to insert a catheter to literally suck the brains from the back of that child's head. That is what happens in the so-called partial-birth abortion.").

2. Dilation & Evacuation Abortions

Another type of abortion is known as dilation and evacuation or D & E. *See Women's Medical*, 911 F.Supp. at 1064. This procedure was described in that case in some detail by the United States District Court for the Southern District of Ohio as follows:

> In the second trimester, the fetus becomes too large to remove by use of suction curettage. At that point, the most common abortion method is a Dilation and Evacuation (D & E) procedure; indeed, it is the only procedure

which can be used from the thirteenth to sixteenth weeks of pregnancy. Instead of using metal rods to dilate the cervix over a short period of time, the doctor inserts laminaria into the cervix during the one-to-two day period prior to the procedure, in order to slowly dilate the cervix. Then, a suction curette with a larger diameter is placed through the cervix, and the doctor removes some, or all, of the fetal tissue.

Frequently, however, the torso and the head cannot be removed in this manner. The procedure typically results, therefore; in a dismemberment of the fetus, beginning with the extremities. This dismemberment is accomplished both by use of the suction curettage, and by the use of forceps [the arms and legs are cut off or pulled off].

Removing the head of the fetus from the uterus is typically the most difficult part of the D & E procedure, in part because the head is often too large to fit through the partially dilated cervix. It is important to remove the head as quickly as possible, because fetal neurologic tissue can negatively affect the mother's ability to clot, and lead to greater bleeding. Physicians have developed different methods of decompressing the head, in order to remove it.

Dr. Anthony Levatino testified that when he performed D & E abortions, he preferred to grasp the fetal head with a clamp, crush it, and remove it in pieces along with the skull contents. Because he decompressed the skull by crushing it, he found it unnecessary to decompress the skull by purposely inserting a suction device into the skull and removing some of its contents.

Dr. Paula Hillard testified that when the skull is too large to remove intact, she grasps the skull and suctions out its contents with a cannula – which may enter the skull – in order to decompress it and facilitate its removal. . . .

Dr. Doe Number One testified that because the use of forceps can cause trauma to the mother's uterus, his preference is to collapse the head by use of suction, prior to its removal. By making a small incision at the base of the skull and inserting a suction device into the brain – while the head is still within the uterus, and no longer attached to the body – he can collapse the head and easily remove it, without the use of forceps. This method decreases injury to the cervix and uterus, and reduces operating room time, blood loss, and anesthesia time. Dr. Doe describes his procedure as a D & E, and collapses the head by the use of suction even in procedures performed from 15 to 18 weeks. . . .

Dr. Mary Campbell has not performed second-trimester abortions, but has read about and observed various second-trimester methods, in preparation for setting up a second-trimester practice at her clinic. In describing the D & E procedure, she testified that the fetal skull is generally not intact following dismemberment of the body – the jaw is often removed with the neck – and "the edges of the fetal skull are sharp enough to lacerate the maternal uterine [blood] vessels. . . . " The goal is therefore to place the suction cannula into the skull in order to remove its contents and make it smaller, thereby allowing it to be removed intact, in order to minimize lacerations. In addition, removing the head intact is advantageous because it ensures that no

parts of the skull are left behind in the woman's uterus.

. . .

The primary distinction between this D & X procedure and the D & E procedure previously described appears to be that, whereas the D & E procedure results in dismemberment and piece-by-piece removal of the fetus from the uterus – and, possibly, in removal of portions of the skull contents by the use of suction after the skull is crushed with forceps or otherwise invaded, and before the head is placed next to the opening to the uterus – the D & X procedure results in a fetus which is removed basically intact except for portions of the skull contents which are suctioned out after the head is placed next to the opening to the uterus (and after the rest of the fetus is removed from the uterus), and before the fetus is fully removed from the mother's body. The hallmark of the D & X procedure, therefore, is that the fetus is removed intact, rather than being dismembered prior to removal, as is done in a D & E procedure. In both procedures, the head usually must be decompressed, either by crushing the skull, or by invading the skull and suctioning out its contents. In the D & X procedure, the suctioning is purposeful; in a D & E procedure, the suction may either be purposeful, or, given the inability to clearly see the fetus, even with ultrasound, and the consequent difficulty of knowing whether the surgical instrument is in, or simply near, the skull, it may be accidental.

Women's Medical, 911 F.Supp. at 1064-66 (emphasis and bracketed material added).

The court in *Women's Medical* concluded that "Assuming that the D & X procedure is 'cruel,' however, this Court fails to see how it is more cruel than the D & E procedure – which involves the dismemberment of the fetus and, sometimes, the crushing of its skull. . . . " 911 F.Supp. at 1074 n. 29. The D & E abortion procedure is the most common abortion procedure in the second trimester (after 13 weeks).

3. Instillation/Induction Procedures

The court, in *Women's Medical*, also described a procedure known as instillation/induction.

> The main alternative to the D & X procedure, in the late second trimester, is the use of an induction method of abortion. Induction methods are also known as "instillation" methods. In one type of induction method, the physician injects some substance – typically saline, or a combination of a prostaglandin and urea – into the amniotic cavity of the woman. In another type, the physician places prostaglandin suppositories into the patient's vagina. In both cases, the end result is labor: the substances cause the uterus to contract, resulting in the eventual expulsion of the fetus. This labor typically lasts between twelve and twenty-four hours, but may last as long as thirty-six hours.

Id. at 1068.

B. Availability of Other Procedures

Under the undue burden test in *Casey*, in order for a statute banning partial-birth abortions to be upheld it is

necessary to show that there are "safe" alternative abortion procedures available. *Women's Medical*, 911 F.Supp. at 1067. The court in *Women's Medical* concluded there are not:

> After viewing all of the evidence, and hearing all of the testimony, this Court finds that use of the D & X procedure in the late second trimester appears to pose less of a risk to maternal health than does the D & E procedure, because it is less invasive – that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent – and does not pose the same degree of risk of uterine and cervical lacerations, due to the reduced use of forceps in the uterus, and due to the removal of any need to crush the skull and remove it in pieces, which can injure maternal tissue.
>
> This Court also finds that the D & X procedure appears to pose less of a risk to maternal health than the use of induction procedures, which require the woman to go through labor, pose additional risks resulting from the injection of fluids into the mother, and cannot be used for every woman needing an abortion.
>
> Finally, the Court finds that the D & X procedure appears to pose less of a risk to maternal health than either a hysterotomy or a hysterectomy, both of which are major, traumatic surgeries.
>
> Because the D & X procedure appears to have the potential of being a safer procedure than all other available abortion procedures, this Court holds that the Plaintiff has demonstrated a substantial likelihood of success of showing that the state is not constitutionally permitted to

> ban the procedure. If this abortion procedure, which appears to pose less of a risk to maternal health than any other alternative, were banned, and women were forced to use riskier and more deleterious abortion procedures, the ban could have the effect of placing a substantial obstacle in the path of women seeking pre-viability abortions, which would be an undue burden and this [sic] unconstitutional under *Casey*.
>
> Even if induction procedures were as safe as the D & X procedure – and this Court does not find, on the evidence, that they are as safe – the requirement that a pregnant woman be hospitalized in order to undergo an induction procedure may also have a negative impact on the practical availability of abortions for women seeking pre-viability abortions. First, hospitals may refuse to allow induction procedures on an elective basis, including those situations in which a woman wishes to abort a fetus with severe anomalies. Second, it may be psychologically daunting to undergo the induction procedure in the hospital environment. These practical problems may discourage women in their second trimester from exercising their right of seeking elective, previability abortions, or make it practically impossible to do so, thereby amounting to an undue burden on the right to seek a pre-viability abortion. In contrast, the D & X procedure can be performed on an outpatient basis within a much shorter period of time, and is not limited by either of these practical problems.
>
> For both of these reasons – because the D & X procedure appears to be the safest method of

> terminating a pregnancy in the late second trimester, and because the D & X procedure is more available than induction methods, which require the woman to be hospitalized – this Court holds that Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the D & X procedure is unconstitutional under *Danforth* and *Casey*.

Id. at 1070-1071.

As is evident from the above-quoted portions of the opinion, the court in *Women's Medical* refused to give legal significance to the fact that under the Ohio statute, the D & X or partial-birth abortion procedure is *not* prohibited where "all other available abortion procedures would pose a greater risk to the health of the pregnant woman than the risk posed by the dilation and extraction procedure." *See* O.R.C. 2919.15(C)(1). This point will likely be argued by the State of Ohio on appeal, as *Women's Medical* is now before the 6th Circuit Court of Appeals (We have obtained and reviewed the briefs from that appeal in preparing this opinion).

Although the findings of the District Court for the Southern District of Ohio are, apparently, the only judicial findings currently available, they are not controlling on Nebraska courts or even necessarily persuasive. We have also reviewed testimony provided to the Congress of the United States by medical experts.

During the U.S. Senate's consideration of H.R. 1833 last November, Nancy G. Romer, M.D. testified before the Senate Judiciary Committee on the medical aspects of partial-birth abortion. Dr. Romer is a practicing obstetrician and gynecologist in Dayton, Ohio and is a diplomat

of the American Board of Obstetrics and Gynecology. She is a fellow of the American College of Obstetrics and Gynecology as well as a clinical professor in the Department of Obstetrics and Gynecology at Wright State University and vice chairman of the Department of Obstetrics and Gynecology of Miami Volley [sic] Hospital in Dayton.

Dr. Romer testified that "In my medical judgment this procedure [D & X or partial-birth abortion] offers no advantage in safety nor efficacy over other methods of termination . . . [I] n my medical judgment, legislation to prohibit the D & X procedure or partial birth abortion does not present a substantial barrier to women seeking late term abortion. There is no medical evidence that this procedure is safer nor necessary to provide comprehensive health care to women. As currently practiced, it does not meet medical standards set by ACOG nor has it been adequately proven to be safe or efficacious." Hearings on H.R. 1833 Before the Senate Judiciary, 104th Cong., 1st Sess. (Nov. 17, 1995) Transcript at p. 112.

We also note that a recent article in the *Washington Times* quotes Dr. Frank Boehm, Director of Obstetrics at Vanderbilt University Medical Center in Nashville, as saying there are "no medical circumstances in which a partial-birth abortion is the only safe alternative." Dr. Frank Boehm, Partial-Birth Abortion Stirs A Medical Debate, Wash. Times, May 6, 1996. Thus, notwithstanding the decision of one judge in Ohio, it appears that substantial evidence could be presented that "safe" alternatives exist to partial-birth abortion.

III. Conclusion

It is essential to keep in mind that the D & X or "partial-birth" abortion ban being challenged in *Women's Medical* is a specific Ohio statute that may be subject to challenges not applicable to a Nebraska statute with different provisions. The Ohio statute apparently covers all abortions involving "inserting a suction device into the skull of a fetus to remove the brain." This fact seemed to play heavily in the decision of the federal district court. In contrast, the partial-birth abortion ban passed by the United States Congress (HR 1833) (and vetoed by President Clinton) banned only abortions in which a living fetus is partially delivered and then killed before delivery is completed.

Thus, it appears that while Ohio has attempted to ban all abortions which involve purposely sucking the brains out of unborn babies, the U.S. Congress attempted only to ban such abortions where the baby is still alive at the time the skull is pierced and the suction tube is inserted in the brain. Many or all of the objections of the District Court in the *Women's Medical* case (whether valid or not) would seem to disappear in the context of the Congressional approach. This conclusion, however, brings to mind the comment of the District Court of Ohio that cutting the arms and legs off a "fetus" inside the mother and crushing its head with forceps (as is done routinely in abortion clinics after 12 weeks in D & E abortions) is arguably no less cruel than sucking a baby's brains out after it is partially delivered.

Degree of cruelty is not the issue here, however. The legal issue presented is whether partial-birth abortions

can constitutionally be banned. The answer is clearly yes, provided the statute does not impose an "undue burden" on women seeking abortions before viability of the fetus. A more specific, and less circular answer, is that it is inconceivable to us that a statute requiring the abortionist to kill the baby *before* its brains are sucked out would place any "undue burden" on women that even the U. S. Supreme Court could identify. A statute which bans all suctioning of brains, however, would be more difficult to uphold given the current state of the law, since it could possibly encompass some D & E abortions if they are not specifically excluded in the statute. However, if evidence shows that suctioning of the brains of living fetuses is never medically necessary, it could be banned outright. The federal district court's decision in southern Ohio has no legal force in Nebraska.

Finally, we would be remiss if we did not state the obvious: The legal question presented by the examination of the constitutionality of partial-birth abortion legislation is so inherently macabre, and utterly divorced from moral or rational foundation that it undermines the credibility of the legal system, and necessarily exposes the moral bankruptcy which is the legacy of *Roe v. Wade*. As the federal district court in *Women's Medical* recently stated, "Never, since the final shot of the Civil War, over a century and a quarter ago, has American society been faced with an issue so polarizing and, so totally incapable of . . . compromise, as is the ongoing controversy, of which this case is but the latest chapter, over the legality of attempts by the State to regulate abortion – the act of voluntarily terminating a pregnancy, prior to full term." *Women's Medical*, 911 F.Supp. at 1056.

Under the current state of Nebraska law, human fetuses or unborn babies are literally afforded less legal protection against cruelty, including dismemberment and death, than stray cats or rodents. It would be a criminal offense under Nebraska law to cut off the limbs of a cat or suck the brains out of a living rat merely to kill it, as is done in partial-birth abortions. *See* Neb. Rev. Stat. S 28-1008, 1009 (1994 Supp.). In contrast, unborn babies, who at 19 weeks can be felt kicking through their mother's body (externally) and who can be seen sucking their thumbs on ultrasound, can legally have their limbs cut off and their skulls crushed with forceps in D & E abortions (which are not the subject of partial-birth abortion legislation) or have their brains sucked out during what would otherwise constitute delivery by a D & X or partial-birth abortion. *See Women's Medical*, 911 F.Supp. at 1065 (discussing testimony of Dr. Harlan Giles, who performs D & E abortions up to the 20th week of pregnancy). This is the legal and medical reality of *Roe v. Wade* and *Planned Parenthood v. Casey*.

In sum, we believe that a partial-birth abortion statute could be drafted that would meet constitutional requirements under applicable decisions of the United States Supreme Court. We note that if the goal of such legislation is to prevent cruelty to late-term fetuses (as was the intent in Ohio), then amendments should also be made to Nebraska's existing statute regulating post-viability abortions (as was done by the Ohio Legislature) since the existing statute may permit other equally cruel abortion procedures to be performed on viable unborn babies. Any statutory changes must, of course, be carefully structured to meet the criteria of *Planned Parenthood*

v. Casey, and should be accompanied by specific statements of legislative intent.

Sincerely yours,

DON STENBERG
Attorney General

/s/ Steve Grasz
Steve Grasz
Deputy Attorney General

Approved by:

/s/ Don Stenberg
Attorney General

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 23

January 22, 1998

CURRICULUM VITAE

NAME:

Frank Henry Boehm, M.D.

OFFICE ADDRESSS:
Department of Obstetrics and Gynecology
Vanderbilt University Hospital
B-1100 Medical Center North
Nashville, Tennessee 37232-2519.

OFFICE PHONE NUMBER:
(615) 322-2071

DATE AND PLACE OF BIRTH:
April 11, 1940
Nashville, Tennessee

SOCIAL SECURITY NO.:
415-62-7104

PERSONAL DATA:

Marital Status:
Married – Julie Goldstein Boehm

Children:
Todd Edward – January 30, 1967

Thomas Ludwig – June 10, 1968

Catherine Valerie – September 2, 1980

Military Service:

1970-1972

LCDR Navy Chief, Department of
Obstetrics and
Gynecology
Bainbridge Naval Training Center
Bainbridge, Maryland

EDUCATION:

1962	B. A. Vanderbilt University Nashville, Tennessee
1965	M. D. Vanderbilt University Nashville, Tennessee

POSTGRADUATE TRAINING:

1965-1966	Internship, Surgery Yale-New Haven Hospital New Haven, Connecticut
1966-1968	Assistant Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
1968-1969	Associate Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
1969-1970	Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
July-Dec. 1969	Fellowship, Surgery and Oncology City of Hope Duarte, California

LICENSURE AND CERTIFICATION:

Tennessee	1965
National Medical Board Exam Certification	1966
Diplomate-National Board of Medical Examiners	1966
Diplomate-American Board of Obstetricians/Gynecologists	1973
Diplomate-American Board of Obstetricians and Gynecologists, Certificate of Special Competence in Maternal/Fetal Medicine	1976

ACADEMIC APPOINTMENTS:

1966-1969 Teaching Assistant, Obstetrics and Gynecology
Yale-New Haven Hospital
New Haven, Connecticut

1969-1970 Instructor, Obstetrics and Gynecology
Yale-New Haven Hospital
New Haven, Connecticut

1970-1972 Chief, Obstetrics and Gynecology
Bainbridge Naval Training Center
Bainbridge, Maryland

1972-1975 Assistant Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1972- Director, Fetal Intensive Care Unit
Vanderbilt University Hospital
Nashville, Tennessee

1975-1981 Associate Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1976-1991 Associate Clinical Professor
Obstetrics and Gynecology
Meharry Medical College
Nashville, Tennessee

1978-1980 Co-Director, Maternal/Fetal Medicine Division
Vanderbilt University Hospital
Nashville, Tennessee

1980- Director, Maternal/Fetal Medicine Division
Vanderbilt University Hospital
Nashville, Tennessee

1981- Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1982- Associate Professor, Radiology
Vanderbilt University Hospital
Nashville, Tennessee

1991- Clinical Professor
Obstetrics and Gynecology
Meharry Medical College
Nashville, Tennessee

HOSPITAL APPOINTMENTS:

1972- Vanderbilt-University Hospital
Nashville, Tennessee

1972-1976 Saint Thomas Hospital, Medical Staff
Nashville, Tennessee

1972-1992 Nashville General Hospital, Medical Staff
Nashville, Tennessee

1972- State Consultant to Perinatal Division of Public Health Department
Nashville, Tennessee

1973-1978 Obstetric Consultant
Florence Crittenton Home for Unwed Mothers
Nashville, Tennessee

1974-present Baptist Hospital, Medical Staff
Nashville, Tennessee

1979-1982 Consultant, Veterans Administration Hospital
Nashville, Tennessee

1983-1987 Obstetric Consultant to Hospital Corporation of America

1986- Clinical and Research Associate
The Center for Clinical and Research Ethics
Vanderbilt School of Medicine

1986-1992 Active Staff; Obstetrics and Gynecology
Hubbard Hospital/Meharry Medical College
Nashville, Tennessee

1995- Centennial Hospital
Nashville, Tennessee

1995- Saint Thomas Hospital
Nashville, Tennessee

PROFESSIONAL ORGANIZATIONS:

American College of Obstetricians and Gynecologists, Fellow

Association of Professors of Gynecology and Obstetrics

Central Association of Obstetricians and Gynecologists

The Clinical Ethics Guild

Davidson County Foundation for Medical Care

Davidson County Medical Society

Nashville Academy of Medicine

Society of Perinatal Obstetricians

Tennessee Obstetricians and Gynecologists Society

Tennessee Perinatal Association

American Institute of Ultrasound in Medicine

Julia Hereford Society Board

The Lonnie Burnett Society

OFFICES HELD:

1980 President Elect, Southern Perinatal Association

1981 President, Southern Perinatal Association

PROFESSIONAL ACTIVITIES:

INTRAMURAL:

1972-1980 Course Instructor – "Human Sexuality"
Vanderbilt University Medical School

1980-1989 Chairman, Third and Fourth Year Medical School Promotions Committee Vanderbilt University School of Medicine

1980- Fund Raiser, Maternal-Fetal Medicine Division Vanderbilt University Medical Center

1981-1984 Co-Director, Genetic Center Vanderbilt University Medical Center

1983-1985 Vanderbilt Hospital Board

1984 Continuing Medical Education Committee Vanderbilt University Medical School

1986-1988 Executive Committee of the Hospital Medical Board Vanderbilt University Hospital

1985- Member, Medical Ethics Committee Vanderbilt University Hospital

1987- Co-Chairman, Perinatal Advisory Committee Vanderbilt University Hospital

1988-1991 Member, University Promotion and Tenure Review Committee Vanderbilt University Hospital

1990-1991 Chairman, Medical Center Faculty/Staff Campaign Vanderbilt University Medical Center

1990-1992 Chairman, Partners in Health Campaign, Vanderbilt University Medical Center

1990- Chairman, Hospital Medical Ethics Committee Vanderbilt University Hospital

1990-1994 Member, Board of Directors Canby Robinson Society Vanderbilt University Medical Center

1992-1993 Member, Academic Programs Committee Vanderbilt University School of Medicine

1992 Member, United Way Committee Vanderbilt University

1993-1995 Member, Networking Committee Vanderbilt University Medical Center

1993- Member, Board, Julia Hereford Society Vanderbilt University School of Nursing

1994 Member, United Way Committee Vanderbilt University Medical Center

1995 Member, Cal Turner. Ethics Scholar Search Committee

EXTRAMURAL

1975- Perinatal Advisory Committee State of Tennessee

1975-1980 Regionalization Coordinator State of Tennessee

1976-1977 Board of Directors, The American Society for Psycho-Prophylaxis in Obstetrics, Inc. Nashville Chapter

1976-1980 Board of Directors, March of Dimes Music City Chapter Nashville, Tennessee

1978 Chairman, Legislative Review Committee Southern Perinatal Association

1978-1979 Chairman, Legislative Committee National Perinatal Association

1979-1989 Staff, Maternal Mortality Committee State of Tennessee

1979 Consensus Development Workshop Sickle Cell Disease Branch National Institutes of Health

1979-1981 Feasibility Study Committee on Sickle Cell Disease National Institutes of Health

1981- Medical-Legal Expert Consultant

1981-1983 Tennessee Malpractice Review Board

1982-1983 Advisor-Symposia Medicus

1982-1988	Board of Directors Tennessee Perinatal Association
1984	Board of Directors Nashville Human Sexuality Council
1984	Grant Review for Chorionic Villus Sampling National Institute of Child Health and Human Development
1985-1988	American College of Obstetricians and Gynecologists Member, Committee on obstetrics: Maternal and Fetal Medicine
1986-1987	American College of Obstetricians and Gynecologists Member, American Academy of Pediatrics Committee on Drugs
1987-1990	Chairman, Legislative Committee of Society of Perinatal Obstetricians
1986-1988	Member, Pediatric Chairman Search Committee
1986-1989	Board of Directors Society of Perinatal Obstetricians
1987-1988	Member, Legislative Workshop, American College of Obstetricians and Gynecologists
1994	Member of International Advisory Committee First World Congress on Labor and Delivery Jerusalem, Israel, July 3-7, 1994
1995	Member, Governor's Appointed TennCare Roundtable
1995	Member, NICHD Task Force on Electronic Fetal Monitoring
1995	Member, Governor's Appointed Graduate Medical Education Task Force

1996	Chair, Tennessee State Task Force on 48 Hour Legislation

EDITORIAL CONSULTANT:

American Journal of Obstetrics. and Gynecology

Journal of the American Medical Association

Journal of Obstetrics and Gynecology

New England Journal of Medicine

Southern Medical Journal

Journal of Clinical Ethics

International Journal of Gynecology & Obstetrics

VISITING PROFESSORSHIP:

July, 1983	Visiting Professor Carmel Hospital Haifa, Israel

ACADEMIC OR PROFESSIONAL HONORS:

Mead Johnson Award for Graduate Teaching

Second Prize, Research Award, District VII, American College of Obstetricians and Gynecologists, 1973 and 1974

Named in *The Best Doctors in America* (Woodward-White, Inc., 1992-1993, 1994-1995 editions), based on national peer recommendations Best Student Teacher, Association of Professors of Gynecology and Obstetrics

Honored at 1993 Roundtable Dinner for Outstanding Educators, Nashville, Tennessee

Named in *The Best Doctors in America: Midwest Region 1996-1997*

Named in Best Internet Sites by *The Nashville Scene*: Doctors Cry Too; hetp://dr-boehm.com

Named in *Good Housekeeping* magazine as one of the country's best doctors for women, August 1997.

OTHER SIGNIFICANT ACTIVITIES:

Member of The Jewish Temple and West End Synagogue

Religious School Teacher, 9th grade, 1980-1985 "Jewish Debate and Dilemmas"

Fund Raiser – Jewish Welfare Fund

Board of Trustees, The Temple, Nashville, Tennessee Chairman, Jewish Outreach Committee, The Temple, Nashville, Tennessee Regular columnist for The (Nashville) *Tennessean*, The (Boca Raton, Florida) *News and MD News* (national magazine for physicians):

"Healing words," presenting medical issues to the general public, 1992-present.

Chairman, Committee Relations Committee, Jewish Federation of Middle Tennessee, 1994-

Board of Directors, Jewish Federation of Middle Tennessee, 1994-

Board of Trust, Harpeth Hall Girl's School of Nashville, 1995-

Southeast Regional Board Anti-Defamation League, 1996

Senator Bill Frist Roundtable Advisor/Member

Executive Council Member, Council Jewish Public Affairs, 1996-present

Board of Directors, Helios Inc., 1996-present

Co-Chair, "Nashville Celebrates Israel's 50th Birthday", project of Jewish Federation, 1998.

OTHER HONORS:

Man of the Year – CABLE (Business Women's organization), 1980.

RESEARCH PROGRAM:

1972	Principal Investigator, Arthur Frank Fund to Vanderbilt University Medical Center to Establish Fetal Intensive Care Unit.
1973-1975	Principal Investigator, Medical Program High-Risk Obstetrics Project Nashville, Tennessee
1973	Principal Investigator, Upjohn Pharmaceutical Company Grant Induction of Labor in Pregnant Women with Orally Administered Prostaglandins
1974-1976	Principal Investigator, Public Health Department, Research Grant to Study Obstetric Regionalization
1975-1976	Principal Investigator, March of Dimes – Middle Tennessee Obstetric Education Grant 1976 Principal Investigator, Syntex Pharmaceutical Company Grant Naproxen in the Treatment of Dysmenorrhea
1976-1977	Participant, National Collaborative Study of Electronic Fetal Stress Testing Long Beach, California
1978-	Principal Investigator Middle Tennessee Obstetric Regionalization Project
1981-1985	Principal Investigator Fetal Monitor Evaluation Litton Monitoring Company Grant Award
1982-1986	Principal Investigator Tennessee Prenatal Program

1982-1987 Consultant, March of Dimes Prevention of Prematurity Study

1983-1986 Principal Investigator Autocorrelation in Fetal Monitoring Hewlett Packard Company Grant Award

1989-1991 Principal Investigator, March of Dimes Prevention of Prematurity Study

1995- Principal Investigator, Nellcor Multicenter Study: Pulse Oximeter Evaluation of Fetal Status

1996- Principal Investigator, TennCare Study on Impediments to Pregnancy Care in Middle Tennessee

CURRENT RESEARCH TOPICS:

Sinusoidal Fetal Heart Rate

Fetal Stress vs Distress

Fetal Pulse Oximetry

PUBLICATIONS:

1. Reynolds VH, Boehm FH, Cohen S: Enhancement of chemical carcinogenesis by an epidermoid growth factor. *Surg Forum* XVI:108-9, 1965.
2. Killen DA, Edwards R, Adkins RB Jr, Boehm FH: Spinal cord ischemia following mobilization of canine aorta from posterior parietes. *Ann Surg* 162:1063-7, 1965.
3. Maudsley R, Boehm FH: Erythrocytosis associated with a fibroid uterus. *Can Med Assoc J* 103:517-8,1970.
4. Boehm FH, Pruett K, Zamore L: Ruptured dermoid cyst in labor stimulating abruptio placenta. *J Reprod Med* 6:229-31, 1970.

5. Boehm FH, Morris. JM: Paget's disease and apocrine gland carcinoma of the vulva. *Obstet Gynecol* 38:185-92, 1971.
6. Boehm FH, Salerno NJ: Menstrual abnormalities in the recruit WAVE population. *Milit Med* 138:30-31, 1973.
7. Acker D, Boehm FH, Askew D: ECG changes with IUD insertions. *Am J Obstet Gynecol* 115:458-61, 1973.
8. Blath R, Boehm FH: Carcinoma of the female urethra. *Surg Gynecol Obstet* 136:1-4, 1973.
9. Boehm FH, Srisupundit S, Ishii T: Lecithin and sphingomyelin ratio and a rapid test for surfactant in amniotic fluid: A comparison. *Obstet Gynecol* 41:829-32, 1973.
10. Boehm FH, Goss DA: The Xerox telecopier and the fetal monitor. *Obstet Gynecol* 42:475-8, 1973.
11. Boehm FH, DiPietro DL, Goss DA: The effect of ampicillin administration on urinary estriol and serum estradiol in the normal pregnant patient. *Am J Obstet Gynecol* 119:98-103, 1974.
12. Boehm FH, Growdon JH Jr: The oxytocin challenge test. *Am J Obstet Gynecol* 119:862, 1974.
13. Boehm FH, Shaw JW: Female sterilization utilizing the laparoscope. *Tenn Med J* 67:656-9, 1974.
14. Boehm FH: Spontaneous hypertonic uterine contractions. *Tenn Med J* 67:660-2, 1974.
15. Boehm FH: The fetal intensive care unit:. An evolving concept. *South Med J* 67:1145-9, 1974.
16. Boehm FH, Growdon JH Jr: The effect of eclamptic convulsions on the fetal heart rate. *Am J Obstet Gynecol* 120:851-2, 1974.

17. Boehm FH, Growdon JH Jr: The effect of scopolamine on fetal heart rate baseline variability. *Am J Obstet Gynecol* 120:1099-104, 1974.

18. Boehm FH, Hodge SJ: Regionalization of a fetal monitoring system. *J Tenn Med Assoc* 68:13-14, 1975.

19. Boehm FH: Prolonged end stage fetal heart rate deceleration. *Obstet Gynecol* 45:579-82, 1975.

20. Boehm FH, Sarratt H: Indomethacin for the treatment of dysmenorrhea: A preliminary report. *J Reprod Med* 15:84-6, 1975.

21. Boehm FH, Woodruff LF Jr, Growdon JH Jr: The effect of lumbar epidural anesthesia on fetal heart rate baseline variability. *Anesth Analg* 54:779-82, 1975.

22. Woodruff LF Jr, Herbert WNP, Ishii T, Boehm FH: Clinical usefulness of the lecithin/sphingomyelin ratio determined by visual means in predicting hyaline membrane disease. *J Tenn Med. Assoc* 69:330-3, 1976.

23. Boehm FH, Hodge SJ, Shaffer FH: Induction of labor with prostaglandin E_2 administered orally. *South Med J* 69:905-7, 1976.

24. Boehm FH, Braun RD, Growdon JH Jr, Sherrell JW: The oxytocin challenge test. *South Med J* 69:884-6, 1976.

25. Boehm FH, Egilmez A, Smith BE: Physostigmine's effect on diminished fetal heart rate variability caused by scopolamine, meperidine and propiomazine. *J Perinat* Med 5:214-22, 1977.

26. Boehm FH: Fetal heart rate variability: Key to fetal well-being *Contemp Obstet Gynecol* 9:57-65, 1977.

27. Sastry BVR, Olubadewo JO, Boehm FH: Effects of nicotine and cocaine on the release of acetylcholine

from isolated human placental villi. *Arch Int Pharmacodyn* 229:23-36, 1977.

28. Haire MF, Boehm FH: Regionalization of a fetal monitoring system: Part II (educational support). *J Tenn Med Assoc* 70:326-7, 1977.

29. Haire MF, Boehm FH: A statewide program to teach nurses the use of fetal monitors. *JOGN* 7:29-31, 1978.

30. Boehm FH, Graber AL, Hicks MM: Coordinated metabolic and obstetric management of diabetic pregnancy. *South Med J* 71:37-42, 1978.

31. Boehm FH, Haire MF: Maternal-transport: An evolving concept. *Am J Obstet Gynecol* 134:484-92, 1979.

32. Boehm FH, Haire MF: Xerox telecopier transmission of fetal monitor tracings: A four-year experience. *Obstet Gynecol* 53:5203, 1979.

33. Boehm FH, Haire MF, Davidson K, Barnett DR, Killam AP: Maternal Fetal transport: Inpatient and outpatient care. *J Tenn Med Assoc* 72:829-33, 1979.

34. Engel E, Empson J, DeLozier D, McGee B, Woodson E, Montmollin M, Carter T, Lorber C, Cassidy SB, Millis J, Heller RM, Boehm FH, VanHooydonk J: Le diagnostic prenatal. *Schweiz Med Wochenschr* 109:998-1010, 1979.

35. Engel E, Empson J, DeLozier D, McGee B, Woodson E, Montmollin M, Carter T, Lorber C, Cassidy SB, Millis J, Heller RM, Boehm FH, VanHooydonk J: Le diagnostic prenatal. Revue, etudes personnelles et perspectives. *Schweiz Med Wochenschr* 109:1054-60, 1979.

36. Boehm FH, Killam AP, Duncan L: The contraction stress test: A comparison of buccal and intravenous

oxytocin and oral prostaglandin E_2. *J Tenn Med Assoc* 72:890-2, 1979.

37. Barrett JM, Boehm FH: Documentation of recent fetal demise with simultaneous maternal and fetal heart rate monitoring. *Obstet Gynecol* 55:28S-30S, 1980.

38. Boehm FH, Killam AP, Chambers JF, Davidson KK: Prostaglandin EZ vaginal suppositories in pregnancy with an anencephalic fetus. *Obstet Gynecol* 55:758-60, 1980.

39. Boehm FH: X-ray pelvimetry in last month of pregnancy (Part I). *Collected Letters of The International Correspondence Society of Obstetricians and Gynecologists* 21:106-7, 1980.

40. Shaff MI, Fleischer AC, Battino R, Herbert C, Boehm FH: Antenatal sonographic diagnosis of thanatophoric dysplasia. *JCU* 8:363-5, 1980.

41. Barrett JM, VanHooydonk JE, Boehm FH: Acute effect of cigarette smoking on the fetal heart rate nonstress test. *Obstet Gynecol* 57:422-5, 1981.

42. Herbert CM, Boehm FH: Prolonged end stage fetal heart rate deceleration: A reanalysis. *Obstet Gynecol* 57:589-93, 1981.

43. Boehm FH, Davidson KK, Barrett JM: The effect of electronic fetal monitoring on the incidence of Cesarean section. *Am J Obstet Gynecol* 140:295-8, 1981.

44. Barrett JM, Salyer SL, Boehm FH: The nonstress test: An evaluation of 1000 patients. *Am J Obstet Gynecol* 141:153-7, 1981.

45. Haire MF, Davidson KK, Boehm FH: Perinatal nursing education in Tennessee: A regional approach. *JOGN* 10:451-4, 1981.

46. Fleischer AC, Killam AP, Boehm FH, Hutchison AA, Jones TB, Shaff MI, Barrett JM, Lindsey AM, James AE Jr: Hydrops fetalis: Sonographic evaluation and clinical implications. *Radiology* 141:163-8, 1981.

47. Barrett JM, Boehm FH, Killam AP: Induced abortion: A risk factor for placenta previa. *Am J Obstet Gynecol* 141:769-72, 1981.

48. Boehm FH, Estes W, Wright PF, Growdon JF Jr: Management of genital herpes simplex virus infection occurring during pregnancy. *Am J Obstet Gynecol* 141:735-40, 1981.

49. Barrett JM, Dean RH, Boehm FH: Rupture of a renal artery aneurysm during pregnancy. *South Med J* 74:1549-50, 1981.

50. Barrett JM, Salyer SL, Boehm FH: Variable decelerations on nonstress test on monoamniotic twins. *Am J Obstet Gynecol* 141:583-5, 1981.

51. Barrett JM, VanHooydonk JE, Boehm FH: Pregnancy-related rupture of arterial aneurysms. *Obstet Gynecol Surg* 37:557-66, 1982.

52. Veren D, Boehm FH, Killam AP: The clinical significance of a sinusoidal fetal heart rate pattern associated with alphaprodine administration. *J Reprod Med* 27:411-4, 1982.

53. Boehm FH, Estes W: Genital herpes simplex during pregnancy. *Perinatology/Neonatology* 6:21-27, 1982.

54. Barrett JM, Staggs SM, VanHooydonk JE, Growdon JH Jr, Killam AP, Boehm FH: The effect of type of delivery upon neonatal outcome in premature twins. *Am J Obstet Gynecol* 143:360-7, 1982.

55. Barrett JM, Boehm FH: Comparison of aggressive and conservative management of premature rupture of fetal membranes. *Am J Obstet Gynecol* 144:12-16, 1982

56. Boehm FH, Fleischer AC, Barrett JM: Sonographic placental localization in the determination of the site of uterine incision for placenta previa. *J Ultrasound* 1:311-4, 1982.

57. Barrett JM, Boehm FH: The problem of premature delivery. *Perinatology/Neonatology* 7:5962, 1983.

58. Boehm FH: Presidential Address: Can society afford perinatal health care? *South Med J* 76:155-7, 1983.

59. Boehm FH, Entman SS: TORCH infections in mothers and their offspring: Current recommendations for diagnosis and management. *Cont Ed Family Physician* 18:357-63, 1983.

60. Diamond MP, Salyer SL, Fields LM, Boehm FH: Improving care of the insulin-requiring pregnant diabetic at a tertiary care center: A preliminary report. *J Tenn Med Assoc* 76:439-44, 1983..

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 24

[LOGO]

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and

4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An

intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American woman. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board

January 12, 1997

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 25

[LOGO] Vanderbilt University Medical Center

[Address Omitted In Printing]

Dear Dr. Levine:

I understand that the Reference Committee is considering the AMA Board's support of HR-1122 concerning the banning of partial birth abortion. Because of this, I would like to have my opinion and, therefore, this letter put into the record.

I am a Professor of Obstetrics and Gynecology at Vanderbilt Medical Center in Nashville. I have been in the practice of obstetrics and gynecology since 1970. I am Director of Obstetrics and the Maternal Fetal Medicine Division at Vanderbilt Medical Center and have held this position since 1980.

I believe that some pertinent information on my views on the subject of abortion is important. I was trained in obstetrics and gynecology before Roe vs Wade was passed in 1973. I observed during this time that because abortion was illegal in this country, many young women were tragically injured or died in the process of obtaining an illegal abortion. Watching helplessly as young women died despite aggressive surgical and medical treatment to prevent death was an experience that I will never forget and has certainly influenced me to this day. It was then and there that I became a strong advocate of choice. Since

1973 maternal mortality in this country has dropped significantly as a result of women throughout this country being able to obtain a legal and safe abortion.

Our group here at Vanderbilt has been offering abortions for significant fetal anomalies as well as maternal illness for the past twenty-five years and because of this, I have not only had considerable experience on the subject of abortion as well as the technique, but I have had an opportunity to reflect on how we as a medical profession approach the process of abortion.

I wish to make it clear that I unequivocally support a ban on the performance of partial birth abortions. The subject of partial birth abortions has become quite controversial as well as confusing. Adding the term "late-term abortion" to the subject has deepened the confusion.

The two mean different things. It has only been recently (January 1997) that the American College of Obstetricians and Gynecologists, a group that I belong to and have worked for in the past, has defined the procedure of partial birth abortion. Prior to this time, there was no definition of this procedure nor any description or research in our literature. A late-term abortion is an abortion performed after the time when a fetus is considered able to have a reasonable chance of survival outside its mother's uterus. There is considerable unanimity of opinion on when this gestational age limit has been reached, and that currently is 24 weeks from a woman's last menstrual period.

Partial birth abortion has never been performed at our institution in the twenty-five years that I have been here, nor to my knowledge has anyone else in the state of

Tennessee performed such a procedure. I have been in contact with all directors of obstetrics throughout the state, as well as virtually all practitioners in the Middle Tennessee area, and I can state with close to 100% certainty that such a procedure has never been performed in our state.

There is never a medical need to perform the procedure as defined by the American College of Obstetricians and Gynecologists as a partial birth abortion. There are potent prostaglandin substances, as well as other mechanisms including oxytocin, as well as the process of dilatation and extraction (D&E), that are proven efficient, relatively rapid, and safe. Most physicians in this country do not offer abortions after viability has been reached (approximately 24 weeks). Delivery after this time, which is needed in order to protect the life and health of the mother, is performed by labor induction or caesarean section with the intent to deliver a live baby. Therefore, there is never a need nor a reason morally, ethically, or legally to perform an abortion in a woman who has reached a 24 week gestational period. Prior to this time, other mechanisms can suffice, and, therefore, it is my strong opinion that there is no indication for this procedure.

In addition, I believe that this particular abortion procedure, which is only performed by a few physicians throughout this country, is morally and ethically difficult to support. While all abortions are in some individuals mind morally and ethically difficult to support, I believe this particular procedure is offensive to even those of us who consider ourselves Pro-Choice. There are many in this country who believe that the Pro-Choice Movement

is abandoning the moral framework and guidance that is needed in this country when considering the process of abortions. This offensive procedure, which results in delivery of a live fetus up to the neck and then literally sucking out its brain causing the fetus to become rigid and then finally limp, is not only emotionally difficult for the health care providers to perform, but difficult to observe by those helping those performing the abortion, as well as the patient herself and her family. In view of the fact that there is no medial need and that there are safe alternatives, it is my opinion that such a procedure should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists.

The language of the bill before you does not include the accepted and relatively safe abortion process called "dilatation and extraction (D&E)". As stated in the bill, "vaginally delivering a living fetus before killing the fetus means deliberately and intentionally delivering into the vagina a living fetus or a substantial portion thereof for the purpose of performing a process the physician knows will kill the fetus and then kills the fetus" clearly does not mean the same as a D&E. The fact that the living fetus has to be totally brought through the vagina or a substantial portion thereof, would preclude any confusion with D&E, which does not bring the entire fetus or a substantial portion into the vagina for the purpose of killing it.

Because of all this, I believe the AMA has performed an important duty in this country by sticking its neck out on a very controversial subject. With 70% of Americans believing that abortion should remain legal, safe, and

rare, I believe that they also wish to have certain moral and ethical guidelines for which this process should be undertaken. Clearly partial birth abortion is an affront to the average American who generally supports the right of choice. Because of this, I believe the AMA is making a strong statement of support of those individuals, including the many physicians who are also in opposition to this procedure.

The banning of partial birth abortion will not change any abortion number and will not infringe on those who do abortions or their ability to perform them in a safe manner. No slippery slope will be stumbled upon, no women will die or lose their health because a partial birth abortion is not available to them.

It is also important to remember that any physician who wishes to cause fetal demise by an intracardiac injection prior to the procedure described by ACOG as partial birth abortion would, in fact, not be violating the law banning its performance because the definition states that "the physician delivers a living fetus before killing the fetus in the vagina." If a physician causes fetal death prior to the procedure itself, that physician would not then be guilty under this definition. Therefore, with this very large loophole, it is clear to me and others that the banning of partial birth abortion is not a medical issue but more a political and moral one.

The AMA's moral leadership in this area is needed, and many physicians who are Pro-Choice will be pleased to

support the AMA's final acceptance on the banning of partial birth abortion.

Sincerely,

/s/ Frank Henry Boehm
Frank Henry Boehm, M.D.
Professor of Ob-Gyn
Director of Obstetrics
Vanderbilt Medical Center
Nashville, Tennessee

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 26

**IN THE CIRCUIT COURT OF
DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE**

PLANNED PARENTHOOD ASSOCIATION OF NASHVILLE, INC., MEMPHIS PLANNED PARENTHOOD, INC., PETER CARTWRIGHT, M.D., FRANK BOEHM, M.D., and WASHINGTON HILL, M.D.	)	No. 92C-1672
Plaintiffs	)	
v.	)	
NED R. MCWHERTER, Governor of the State of Tennessee, in his official capacity, *et al.*	)	
Defendants.	)	

AFFIDAVIT OF FRANK BOEHM, M.D.

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, FRANK BOEHM, M.D., having been duly sworn, do state as follows:

1. My name is Frank Boehm, M.D., and I have personal knowledge of the facts contained in this affidavit. I submit this affidavit in support of plaintiffs' motion for a temporary restraining order or preliminary injunction.

2. I am a physician licensed to practice medicine in the State of Tennessee. I am board certified in obstetrics and gynecology and in maternal fetal medicine, and have practiced in those areas since 1966. I am a fellow of the American College of Obstetricians and Gynecologists (ACOG). I am currently a professor of Obstetrics and Gynecology at the Vanderbilt University School of Medicine. In addition to my teaching duties, I have a private practice treating high-risk obstetrics patients and consulting in problem pregnancies. During the course of my practice, I perform and supervise abortions and advise women seeking abortions.

3. I have reviewed the Tennessee criminal abortion law being challenged in this case. It is my opinion based on my experience and professional expertise that the statute will cause health risks and unnecessary mental anguish for women seeking abortions in this state, will make it more onerous and expensive for women to obtain abortions, and will prevent many women from obtaining safe and legal abortions. If this statute goes into effect, I believe that the number of illegal and dangerous "back alley" abortions in Tennessee will increase. In addition, the statute is confusing and badly drafted, and does not give me or other physicians advising pregnant women fair warning of how to avoid criminal penalties.

HOSPITALIZATION REQUIREMENT.

4. The requirement that abortions after the first three months of pregnancy be performed in a hospital is confusing and unclear to me as a physician. The term "three months" of pregnancy is not defined in the statute. Modern obstetrical practice generally measures the length of pregnancy from the first day of the woman's last menstrual period (LMP), although actual conception or fertilization occurs two weeks after this point. As a physician, when I say that a woman is twelve weeks pregnant, I mean that twelve weeks have elapsed from the beginning of the woman's last menstrual period (LMP). Generally, however, only ten weeks have elapsed since conception occurred. I have no idea whether the phrase "first three months of pregnancy" in the statute relies on general obstetrical practice to measure the length of pregnancy from the date of the last menstrual period, or whether it measures the pregnancy from the date of conception. In addition, it is not clear whether "the first three months" refers to calendar months (approximately twelve weeks) or whether it means the "first trimester" of pregnancy, which is approximately fourteen weeks LMP.

"INFORMED CONSENT" REQUIREMENTS.

5. The requirement that physicians, rather than qualified counselors, provide the informed consent information required by the statute is unnecessary and will merely make abortions more expensive and difficult to obtain.

6. Some of the "facts" that the statute directs physicians to tell women seeking abortions are false and misleading. In addition, the provisions are confusing and contradictory and do not give me or any physician clear notice of what we must tell women seeking abortions.

7. The requirement that physicians tell women that abortion in a considerable number of cases is a major surgical procedure is obviously wrong. Abortion is almost never a major surgical procedure.

8. The requirement that physicians tell women that numerous public and private agencies are available to assist her during pregnancy and after the birth of her child, and give women a list of such agencies on request is inaccurate, misleading, and unclear. Although it is my practice to assist women considering abortion by telling them about the agencies and services of which I am aware and by fully discussing with them their options. I do not believe that "numerous" agencies and services exist, especially with regard to assisting women after birth if they choose not to give their child up for adoption. I have never attempted to formulate a list of such agencies and services and believe that it would be impossible to do so within the terms of the statute.

9. The requirements that physicians tell women of the "risks and benefits" of abortion or continued pregnancy and of the "particular risks" of her situation are confusing and redundant. Although I always discuss with a woman seeking an abortion the risks of her situation, I have no idea of how to address the "benefits" of abortion or continued pregnancy. Moreover, to my mind the separate requirements that physicians discuss the "risks and

benefits" and the "particular risks" mean the same thing. I am unsure, from reading these provisions, of what the statute requires me to tell a woman in order to avoid criminal penalties.

10. I believe that in many cases among my patients the requirement that I go through these "facts" with the woman seeking an abortion is unnecessary, inconsistent with good medical practice, and punitive. Often, my patients are seeking abortions because their fetus is seriously malformed or for other medical reasons. In such situations it is cruel and inconceivable that I am required to tell a woman that there are numerous agencies available to assist her if she chooses to keep her child or that I am required to describe the numerous benefits of continued pregnancy, as in many instances a continued pregnancy is not even an option to them.

WAITING PERIOD.

11. The three day waiting period mandated by the statute provides no benefit to a woman seeking an abortion, and will only make obtaining abortions more difficult and expensive, especially for poor women who may have traveled to Nashville from rural areas in order to obtain an abortion. In addition, in many cases this waiting period requirement will prevent women from obtaining abortions at all. For these women, waiting the three days prescribed by the statute will take them past the term of pregnancy (fourteen weeks LMP) during which Planned Parenthood will perform an abortion. Abortions after this period are unavailable in Nashville for women with healthy fetuses.

12. This waiting period requirement will be particularly difficult and punitive to women among my patients who are seeking abortions because of malformed fetuses. Making such women wait to obtain an abortion is unnecessary, inconsistent with good medical practice, and cruel.

PARENTAL NOTIFICATION.

13. In my opinion, the requirement that both parents of a minor be notified of her decision to seek an abortion, and the lack of provision for judicial bypass of this notice, will lead to an increase in illegal and dangerous "back alley" abortions. Those minors who are unable to notify their parents of their pregnancy, and who are unable to get a legal abortion without such notification, may well seek abortions through illegal channels. I saw the horrible results of such illegal abortions during my practice before safe and legal abortions were readily available, and I believe that a resurgence of these cases will occur if this statute is not enjoined.

Further affiant sayeth not.

/s/ Frank Boehm
Frank Boehm, M.D.

Sworn to and subscribed before me on this the 23rd day of July, 1992.

/s/ Patricia A. Adam
Notary Public

My commission expires:

September 24, 1994

Respectfully submitted,

Barbara E. Otten
Roger K. Evans
Dara Klassel
Planned Parenthood Federation
of America, Inc.
810 Seventh Avenue
New York, NY 10019
(212) 541-7800

Barry Friedman, #14567
Cooperating Attorney, ACLU
Foundation of Tennessee
Vanderbilt University School
of Law
21st Avenue, South
Nashville, TN 37240
(615) 322-2615

Steven R. Shapiro
Eve Cary
American Civil Liberties
Foundation
123 West 43rd Street
New York, NY 10036
(212) 944-9800

Elizabeth R. Thompson, #14505
Sherrard & Roe
424 Church Street
Nashville, TN 37210
(615) 742-4200

Of Counsel: Edward M. Kaplan, #8102
Teresa J. Sigmon, #10106
Armstrong, Allen, Prewitt
Gentry, Johnston & Holmes
Suite 1900
Memphis, TN 38103
(901) 523-8211

/s/ Irwin Venick
Irwin Venick #4112
WOODS & VENICK
121 Seventeenth Avenue,
South
Nashville, TN 37203
(615) 259-4366

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent by regular U.S. Mail, postage prepaid to Mike Catalano, Counsel for Ned R. McWherter, Deputy Attorney General, 450 James Robertson Parkway, Nashville, Tennessee 37219 and Victor Johnson, Assistant Attorney General, Metropolitan Courthouse, Second Floor, Nashville, Tennessee 37201 this 23 day of July, 1992.

/s/ Irwin Venick
IRWIN VENICK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 27

VIDEOTAPED DEPOSITION OF
FRANK HENRY BOEHM, M.D.

Friday, January 23, 1998

[p. 2] The videotaped deposition of FRANK HENRY BOEHM, M.D., was taken by counsel for the Defendant at the offices of Dr. Boehm, Vanderbilt University Hospital, B-100 Medical Center North, Nashville, Tennessee, on Friday, January 23, 1998, beginning at approximately 11:30 a.m., for all purposes allowed under the Federal Rules of Civil Procedure.

It is agreed that Carol A. Nichols, Registered Diplomate Reporter, Certified Shorthand Reporter, and Notary Public for the State of Tennessee at Large, may swear the witness, take the deposition, and afterwards reduce same to typewritten form, and that the reading and signing of the completed deposition by the witness is waived.

All formalities as to caption, certificate, transmission, filing, et cetera, are waived. All objections are waived, unless stated during the deposition.

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[p. 3] EXHIBITS

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*Retained by Counsel

[p. 4] FRANK HENRY BOEHM, M.D.,

having been duly sworn, was examined and testified as follows:

(Exhibit 23 marked.)
(Exhibit A marked.)

MR. SMITH: Just for one housekeeping matter, the Notice of Deposition for this deposition has been marked as Exhibit A. I would offer it to be part of the record of the deposition. Do you have any objection, Mr. Heller?

MR. HELLER: No.

MR. SMITH: And would also state for the record that the parties have stipulated that all objections are waived unless made during the deposition; is that agreeable?

MR. HELLER: Yes.

EXAMINATION

BY MR. SMITH:

Q. Would you state your name, please?

A. Frank Henry Boehm.

Q. And what do you do for a living?

A. I'm an obstetrician/gynecologist at Vanderbilt Medical Center.

[p. 5] Q. Okay. And as far as your medical specialty, what is your medical specialty?

A. Well, it's obstetrics and gynecology with a subspecialty of maternal-fetal medicine.

Q. And are you certified by any American boards of medical specialties?

A. Yes. I am certified by the American Board of Obstetrics and Gynecology in both obstetrics and gynecology and maternal-fetal medicine.

Q. And you're a licensed physician by the state of Tennessee; is that correct?

A. Yes.

Q. And, Dr. Boehm, I'm showing you your curriculum vitae that's been marked as Exhibit 23. Is your curriculum vitae, Exhibit 23, is that accurate?

A. Yes, it is.

Q. And it's accurate concerning your education [sic] and your professional credentials?

A. It is.

Q. Now your curriculum vitae reflects that you completed your medical education and your residency training prior to the United States Supreme Court decision in Roe v. Wade; is that correct?

A. Yes.

Q. And it would then be an accurate statement [p. 6] necessarily that your basic educational training in obstetrics was completed when abortions were illegal in this country, correct?

A. That's correct.

Q. And prior to the legalization of abortions, did you treat women who had complications arising out of illegal abortions?

A. Yes.

Q. And can you generally tell us what your experience was in that regard?

A. Well, when I started obstetrics, I was a young kid who really didn't have much of an opinion about the matter of abortion. It was not table conversation when I grew up or even when I went to school. But becoming a

resident in obstetrics and gynecology in New Haven, Connecticut, in the middle '60s, it brought me face to face with the problems that women throughout this country were facing when they were dealing with an unwanted pregnancy. Virtually every night a woman was admitted to the Yale-New Haven Hospital emergency room with complications of an illegal abortion. And so therefore the experience that myself and my fellow residents had in dealing with this condition and problem was considerable. It convinced me that we had a real [p. 7] problem in this country where women were going to have illegal abortions that were quite unsafe and especially many of the poor women. The more wealthy seemed to go out of the country or to find other techniques. But still it was both rich and poor alike that we admitted. Many of the women were admitted severely ill and required long hospitalizations often with loss of fertility. Some we did hysterectomies to save their life. And on several occasions I was present and pronounced dead women who died of complications. Within a few years of this experience, I became a strong advocate for choice and for a change in the law that we had existing in this country.

Q. And to understand your personal views concerning the subject of abortions, do you have personal views?

A. Sure. I have not wavered in my advocacy of the pro-choice movement. I also consider myself pro-life though. I think most physicians don't like to have to use those terms "pro-choice" and "pro-life". I do like to think of myself as a promoter of life. On the other hand, I believe choice as defined by Roe v. Wade is reasonable. I believe we have laws in this country that protect a woman's choice.

[p. 8] So I have always been an advocate of pro-choice, but I have also been an advocate of limitations, assuming they're not unduly burdensome to the woman, is also appropriate and demonstrates responsible behavior by society and more specifically by physicians and health care providers performing abortions.

Q. Okay. And since Roe v. Wade and the legalization of abortions in this country, have you performed abortions, yourself?

A. Yes.

Q. And can you give us – attorneys always throw out – want to know the numbers. Can you give us an approximation of the number of abortions you have performed in the last 25 years?

A. It's certainly less than 1,000, but I couldn't give you an exact number.

Q. Okay. As far as any range, are you able to give any estimate of a range?

A. I really can't.

Q. You think you have performed over at least 100 abortions?

A. Oh, yes. It's more than 100, and if we go back to the early 1970's through to today, it's more than 100 but certainly less than 1,000. The abortions [p. 9] that I do are generally second trimester, congenital anomaly abortions where we have serious malformations of the fetus. I think that's the gravest percentage of abortions that I do and have done in the last 25 years.

Q. Do you consider yourself knowledgeable on the subject of abortion?

A. Yes.

Q. Do you consider yourself a medical expert on abortion procedures?

A. Yes.

Q. And the abortions that you've performed in your or – strike that. The abortions that you've performed in your medical career, have you done those strictly in a hospital setting or in a hospital and clinic setting?

A. Well, the first trimester abortions that I have done have been in a clinic setting or outside the hospital, although maybe attached to the hospital since that's what we have here at Vanderbilt. All second trimester abortions have been done in a hospital.

Q. And you're familiar that the American Medical Association did a study last year on abortions?

A. Yes.

Q. And I'm showing you what's been marked as Exhibit 7, which is the Exhibit 7 for the trial, which [p. 10] is a portion of the American Medical Association report. And if you would, turn to the page, page number 6 at the top of the page of Exhibit 7. Down at the bottom it says, "Procedures used to induce abortion." Do you see that?

A. Yes, I have it.

Q. Okay. And as far as the procedures starting on that page going through the next page on first trimester procedures and on the following page, it's page number 8

at the top, describes mid trimester and third trimester procedures to induce abortions and continuing on the following page number 9, the abortion procedures that are described on the pages just indicated, are you familiar with those procedures?

A. Yes.

Q. And do you take any or have any disagreement with the American Medical Association's paper, Exhibit 7, as far as their description of the procedures?

A. No.

Q. Now when is the last time you performed an abortion?

A. We're probably talking about just weeks ago. We have patients who are admitted to our labor and delivery suite for this. And if I'm the attending [p. 11] on call, almost every time that I take a week on call, which is every five weeks, there are patients who are admitted under my name for prostaglandin termination of second trimester abortions. So I would be the doctor of record as having participated and performed the abortion.

Q. And as far as the approximate number of abortions you may have performed in the last year, do you have any idea what that might be?

A. Certainly more than a dozen.

Q. Do you do what could be described as elective abortions?

A. No.

Q. And what do you understand an elective abortion to be?

A. Well, an elective abortion, for purposes of this definition, would be someone who just doesn't want to be pregnant. There are no risk factors, no maternal health problems, a pregnancy that is not wanted at that particular time in a woman's life.

Q. Okay. But if a woman comes to you as a patient – and I assume you've had women come to you as patients who wanted to have an elective abortion; that's happened, correct?.

A. Oh, yes. If a patient that is one of my [p. 12] private patients comes in and wants an elective abortion, which happens very rarely, but if it were to happen and has happened in the past, I will recommend that she go to one of our two abortion clinics here in Nashville for a first trimester abortion. If that's unacceptable to her and she asks me to do it at Vanderbilt as an outpatient in the first trimester, I will do that.

Q. Now as far as just your source of your knowledge, experience, background on abortions, do you discuss abortions with other physicians who perform them?

A. Sure.

Q. Okay. Discuss abortion techniques?

A. Yes.

Q. Okay. Share professional knowledge as far as their experiences in doing abortions?

A. Yes.

Q. And has this been something, a practice of yours over your entire professional career?

A. Yes.

Q. Okay. And as far as – just to have an idea as to who might be the numbers of physicians that you have that perform abortions that you have such conversations with, any idea as to –

[p. 13] A. How many?

Q. Yeah.

A. Dozens, dozens. Remember, I teach at Vanderbilt, so I've talked to medical students and nurses and doctors and it's in the hundreds if you include medical students and nurses, residents, colleagues around the country. Let me change that number from dozens to hundreds.

Q. Okay. And you anticipated my next question is do you teach abortion techniques here at Vanderbilt?

A. Yes.

Q. And do you have any teaching or supervisory responsibilities for residency programs?

A. Yes.

Q. And those would be residency programs in obstetrics and gynecology?

A. That's correct.

Q. And do you instruct on abortion in the residency programs also?

A. Yes.

Q. As far as your experiences, what would be the approximate latest gestation that you've ever performed an abortion?

A. We would stop once a patient reaches 23 weeks.

[p. 14] Q. And you stop why?

A. Because at 24 weeks there is a reasonable chance of survival which is about 50 percent at this particular point in time.

Q. You're referring to the fetus?

A. The fetus, and because 23 weeks includes 23 weeks and 6 days, we give ourselves a week of buffer so to speak so we don't make any errors or minimize the error as much as possible. And so we do not do abortions after 22 weeks and 6 days. That's from the last menstrual period.

Q. Okay. And your explanation would assume that you are familiar just with the statistical data on viability of fetuses?

A. I am aware of statistical data on survivability. Viability is defined by many states differently and by individuals differently. My definition is accepted by many although it may not be the only definition, and that is the time in which a fetus has a reasonable chance of survival outside its mother's uterus.

Q. You would consider that to be 23 weeks?

A. Well, I would consider that to be 24 weeks.

Q. And 23 weeks would be -

A. But at 23 weeks there's approximately a 10 to 15 [p. 15] percent chance of survival with a 90-plus percent severe morbidity. So I don't really like to consider 23 weeks, but when you are Director of Obstetrics and you have to come up with rules and regulations, which is what I have to do, we have set as an outer limit 23 weeks so that we didn't get into the problem of being so close to 24 weeks that we made errors. So I still consider viability to be 24 weeks.The reason we use up to 23 weeks at Vanderbilt is a procedural, technical reason rather than an actual definitional interpretation of viability.

Q. As far as the type of abortion procedures that you've performed yourself, could you tell us what type of abortion procedures you've performed in your experience?

A. Well, I've performed the D & C and the suction D & C in the first trimester. I've performed some D and E's earlier in my career although I haven't, as I think I've indicated – not performed a D & E myself as a sole provider in ten years at least. I performed saline abortions years ago, installation of prostaglandin, intraamniotic, and I have participated in hysterotomies. And I have participated in more recently the use of prostaglandin drugs to initiate labor and delivery.

[p. 16] Q. Are you aware of an abortion procedure known as the dilation or dilatation and extraction procedure?

A. The D & X procedure?

Q. Yes.

A. Or the D & E procedure?

Q. D & X.

A. D & X. That's the intact D & E or D & X. Yes, I'm familiar with it inasmuch as I've read about it.

Q. Okay. Have you actually performed such a procedure?

A. No.

Q. Have you ever been present when any other physician has performed such a procedure?

A. No.

Q. Okay. And if you would, turn to Exhibit 8, page number 8 at the top. In the last paragraph there of page 8, Exhibit 7, the AMA report describes the intact D & X procedure. Do you see that?

A. Yes.

Q. Okay. And the second-to-the-last sentence states, "This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs." Do you see that?

[p. 17] A. Yes.

Q. Do you know if that has ever been proven medically?

A. No. I think the sentence indicates that it may, but it also indicates that it may not. There's never been to my knowledge any studies that have compared the trauma to a woman's uterus, cervix, or other vital organs with either technique.

Q. Do you view that sentence as being in the context of theory?

A. Yes.

Q. And the next sentence says that an intact D & X may be preferred by some physicians continuing through the rest of the sentence. Do you see that?

A. Yes.

Q. And again as far as that being a statement of fact, do you have any understanding as to whether or not some physicians may prefer the intact D & X, if you know?

A. Well, I think it's the same here. It may would also include to may not. I think it bridges on the realm of possibilities that there are instances where a fetus has been diagnosed with hydrocephaly, as the sentence concludes, or other abnormalities incompatible with life outside the womb. So I don't [p. 18] have any reason to disagree with it, but I don't know of any studies that would indicate the numbers of doctors that fall into the category that may versus those who may not.

Q. Okay. Now as far as the significance to you as a physician applying medical standards, is there a distinction between something which has been medically proven and something which is medical theory?

A. Oh, huge, huge difference.

Q. And can you explain what the distinction would be as far as medical standard?

A. Sure. Medical standard comes from many years of study of a certain procedure, for example, that has

been compared and described in the literature and studied as to its safety compared to other techniques. For example, a procedure would be performed on 4- or 500 patients, half of which would have one procedure, the other half would have the other procedure, then outcome data would be looked at, statistical significance would be applied, and conclusions would be reached. The scientist or the investigator would then send that to a journal. That would be reviewed by statisticians, by other doctors knowledgeable in that field. The study would then be deemed acceptable or [p. 19] unacceptable and it would be published. And it's a body of this publication of work of a procedure or a technique or a theory that eventually is proven or disproven based on that body of work and the scientific studies that have undergone to try to understand whether that technique is in fact safer or better or shorter or cheaper or whatever the intention of the study is.

That's how standard of care comes. A theory is just a theory and has never been proven by anyone to be fact.

Q. Okay. Now the intact D & X procedure and particularly the second-to-the-last sentence as described in the AMA report on page 8, Exhibit 7, has that ever been medically proven in the method that you've described as far as the procedure would minimize trauma to the woman's uterus, cervix, and other vital organs?

A. No.

Q. Are you aware of any ongoing studies in that regard?

A. No.

Q. The intact D & X as described in the AMA report refers to the American College of Obstetricians and Gynecologists, correct?

[p. 20] A. Yes.

Q. And are you familiar with the American College of Obstetricians and Gynecologists' statement of policy?

A. Yes.

Q. And I'm showing you what's been marked as Exhibit 24. Is that the American College of Obstetricians and Gynecologists' statement of policy on intact D & X procedures?

A. It is.

Q. And at least Exhibit 24, the policy reflects that it was approved by the executive board in January of '97. And prior to the American College of Obstetricians and Gynecologists approving the statement of policy, are you aware of whether the intact dilatation and extraction procedure had ever been described in any medical text?

A. It had not been.

Q. Had it appeared the intact D & X procedure been described in any peer review literature prior to the ACOG statement of policy?

A. It had not, and that's why the American College of Obstetricians and Gynecologists put out a statement of policy, because it had been discussed in the press and it had no definition by our organization [p. 21] and our professional group anywhere so that it needed some definition, and this is what ACOG came up with.

Q. And what is your affiliation, if any, with ACOG?

A. I'm a member.

Q. And have you ever in the past been involved in developing any ACOG policy statements?

A. I have.

Q. And I take it those would be described in your curriculum vitae?

A. What would be in my vitae is the years that I spent on various committees where that was – where writing policies and assisting in consulting on policies when that work was done.

Q. And the ACOG policy statement, Exhibit 24, if you would turn to the second page, do you see the sentence that says, "An intact D & X however may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman. And only the doctor in consultation with the patient, based upon the woman's particular circumstances, can make this decision." Do you see that?

A. Yes.

Q. Do you agree or disagree with that?

[p. 22] A. Well, I disagree.

Q. Why?

A. Based on the fact that there's no data to support either one. Again, ACOG says it may be the best. It doesn't say that it is or that there's any data to support that. It is still theory in the same context as was discussed earlier by the AMA's wording.

Q. Now the executive board of the ACOG that approved the policy statement, do you know any of the members of the executive board?

A. Yes.

Q. And have you communicated with any of those board members concerning this ACOG statement of policy?

A. Yes.

Q. And who would that be?

A. One in particular, Dr. Ralph Hale, the Executive Director.

Q. Of the executive board?

A. Well, he's Executive Director of the American College of Ob/Gyn. I don't know if he served specifically on this particular executive board. I would imagine he did, but I don't know that for sure.

Q. Have you made your views known to him concerning your disagreement with the aspects of the second page of the policy statement?

[p. 23] A. Yes.

MR. HELLER: Objection just as to relevance, whether he made his views known to ACOG.

BY MR. SMITH:

Q. And what's your – did you receive any response from him concerning whether or not the sentence previously read as far as the intact D & X being the most appropriate procedure, as to whether or not that was theory or proven?

A. His response to me –

MR. HELLER: Objection, hearsay.

THE WITNESS: His response to me did not deal with that particular question. It dealt with other aspects but not with that one.

BY MR. SMITH:

Q. Do you have an opinion as to the relative safety of the intact D & X procedure versus other abortion procedures as it relates to a woman's health?

A. I don't have a real opinion about it other than that I don't know. No studies have been done to show outcome, one compared to another.

Q. Okay. In your medical opinion are there any situations in which an intact D & X abortion procedure would be a safer abortion procedure for a woman than another abortion procedure?

[p. 24] A. No.

Q. I'm trying to remember my question. I can't recall if I asked you if you have an opinion or – let me back up. Do you have a belief, one way or another, whether an intact D & X procedure would be safer in any medical situation for an abortion than any other abortion procedure?

A. I have an opinion.

Q. Okay. What is your opinion?

A. I don't have any evidence that it is safer, so my opinion is that without data to support it, I don't know.

My answer has to do basically with trying to be – trying to bring up theory and have that result in fact. And without facts I couldn't possibly answer that question. I believe there are very safe alternatives, but I know of no study that compares procedures with the D & X.

Q. Now I'm showing you Nebraska's partial birth abortion bill. It's Legislative Bill 23. Have you previously reviewed the bill?

A. Yes.

Q. Okay. And at least the bill in the form it appears – and I believe it's attached to the plaintiff's complaint – on page 4 starting at line 9, it has a definition of partial birth abortion. And [p. 25] you're aware that that was the definition of LB23 in Nebraska?

A. Yes.

Q. And that that – as described, partial birth abortions are banned in Nebraska by that particular legislation?

A. Yes.

Q. Do you – as a physician do you understand the definition of partial birth abortion as drafted by Nebraska's LB23?

A. I believe I do.

Q. Okay. And does Tennessee also have a partial birth abortion bill?

A. Yes.

Q. Okay. And would you agree that the definition of partial birth abortion in Tennessee is the same as

Nebraska's except Tennessee uses the word "fetus" rather than "unborn child"?

A. Yes.

Q. And Tennessee also bans partial birth abortion; correct?

A. Yes.

Q. Now in your opinion would the banning of the partial birth abortion as defined by LB23, would that create any adverse medical risk to the health of [p. 26] any woman seeking an abortion?

A. It would not.

Q. And why do you say that?

A. Because there are safe alternatives.

Q. And the alternatives would be what?

A. Well, the basic one would be induction of labor with chemical compounds such as prostaglandin.

Q. And that's typically done in a hospital; correct?

A. Yes.

Q. As far as are there safe alternatives that could be performed in a clinic setting?

A. D & E's can be done and are done in clinic settings, usually not beyond 18 weeks, but that could be done as a safe alternative in a clinic setting.

Q. Now the ban of partial birth abortions in Tennessee, does the Tennessee ban affect your ability to perform medically safe abortions?

A. No.

Q. To your knowledge does the Tennessee partial birth abortion ban affect the ability of any Tennessee physician to perform medically safe abortions?

A. No.

MR. HELLER: Objection. Foundation [p. 27] for his knowledge and relevance.

THE WITNESS: No.

BY MR. SMITH:

Q. Do you know of any Tennessee physician who performs or has performed a partial birth abortion as described by the Tennessee legislation?

MR. HELLER: Objection again as to relevance.

THE WITNESS: No.

BY MR. SMITH:

Q. Have you made any specific inquiries in that regard to find out if physicians performing abortions in Tennessee have performed partial birth abortions?

A. I have.

Q. And can you tell us what you have done as far as making inquiries in that regard?

A. I've called my colleagues all across the state from Memphis, including abortion providers here in Nashville, Directors of Obstetrics and individuals who are knowledgeable about what goes on in their community about concerning abortions in Knoxville, Chattanooga, and the Tri-City area of Kingsport, Bristol, and Johnson City.

Q. Okay. And your inquiries, do you believe [p. 28] they have allowed you to determine what is the state of practice, at least in the state of Tennessee, on partial birth abortions?

MR. HELLER: Objection. I don't think his field of expertise includes surveys of physicians in Tennessee.

BY MR. SMITH:

Q. Go ahead and answer the question.

A. I believe within the limitations mentioned that it does allow me to have a reasonably good handle without a doctor-by-doctor survey as to what is going on in the state of Tennessee as far as abortion techniques are concerned.

MR. HELLER: Again, I'm just going to object based on the relevance of what's going on in Tennessee.

MR. SMITH: And if I could state for relevance, the relevance to me is at least on the procedure, LB23 has the same partial birth abortion definition of ban as does Tennessee.

BY MR. SMITH:

Q. That being said, Doctor, are you aware of any physician in Tennessee, based on your inquiries, that has not been able to perform the abortion technique described in the partial birth abortion ban [p. 29] because of the ban?

A. No.

Q. Now do you also here at Vanderbilt teach medical ethics?

A. Yes.

Q. And can you give us a little overview as to what your involvement would be with the responsibilities for teaching medical ethics?

A. Well, I am Chairman of the Vanderbilt Medical Center's Ethics Committee and have been that for approximately six years so that I teach ethics and help with ethic policy in the hospital or review policy that may affect ethics. And I participate in a large number of different educational opportunities for our entire medical facility.

Q. And how long has that been the case as far as your teaching and your responsibilities for medical ethics?

A. Well, I've been interested in ethics for 15 years or so and have served on the committee but have only been chair of that committee for – I think this is my seventh year.

Q. Okay. And your interest would be the interest as far as teaching and from an academic interest?

[p. 30] A. I think medical ethics is an important part of medical education and needs to be taught to students and residents and others because it is part of what we do and how we do things.

Q. Now the ban on partial birth abortions as drafted by LB23 and a similar legislation in Tennessee, does that have any effect or relationship with the ethics of the medical profession?

A. I believe it does.

Q. And can you explain what the relationship and effect would be?

A. Sure. I believe that it is the responsibility of the medical profession, especially those of us who are responsible for teaching and carrying out certain procedures like abortion, that there needs to be certain guidelines, a certain framework that doctors work – doctors and nurses work within.

And I believe that those guidelines should be respectful of certain elements including the taking of a human life which is done through an abortion. And I think those of us who are interested in this subject are the ones that are responsible for speaking out when individuals in our community, medical community step over the line that we believe is made in [p. 31] differentiating what is morally and ethically acceptable and what is not.

And while I'm the first to admit that that depends on the individual and that there are many individuals who would say that any abortion is morally unacceptable, I believe those of us who believe ourselves to be supporters of women's rights to choose, that that choice does need some limitations, some boundaries. And many of them are boundaries that are defined by morality and ethics.

And so that is really where I came to the conclusion that this particular procedure, the partial birth abortion, stepped over that line. And because of that and the fact that it wasn't needed to begin with should be a place where we make a stand and say, This is unacceptable, and other things may be acceptable, but this is not acceptable.

Q. And as what you said relates to medical ethics as I understood it, the ethics would be doing an abortion procedure which is not medically necessary?

A. I think that would be characteristic of it. The field obviously gets somewhat confusing because the term "late term abortions" have also been part of this particular process. Again, "late term abortion" has no meaning in medicine. If it means post-viability, then [p. 32] I think abortions – again, to offer abortions after viability is one of those other steps across that line that makes it unethical and immoral.

And so when you put the two together, for many of us who are interested in this field, I believe that it represents a departure from what is morally and ethically acceptable by the medical profession and especially those of us who agree with pro-choice and who perform-abortions.

Q. Now the legislative ban on partial birth abortion as defined by LB23, would that ban mean that a woman seeking abortion would have to go an alternative procedure which would create a higher risk of harm to her uterus, cervix, or internal organs?

A. No.

Q. And why do you say that?

A. Well, for a variety of reasons. One is that we've been performing abortions for years on women safely with other techniques, and we don't have any data that would say that another technique such as partial birth abortion is any safer.

Q. Do you know what the medical term disseminated intravascular coagulopathy, what that means?

A. Sure.

[p. 33] Q. Did I pronounce it right?

A. Sure, you did a good job.

Q. Can you tell us what it is?

A. It is a condition where the patient's blood does not clot and throughout the body disseminated; intravascular meaning inside the vessels of veins and arteries, the blood doesn't clot. And that comes from a variety of medical factors that causes this – that condition.

Q. And would banning the partial birth abortion as defined by Nebraska's LB23, would that increase the woman's risk of disseminated intravascular coagulopathy?

A. No.

Q. And why not?

A. Well, first of all, the abortions don't result in DIC. That might make it easier for you. We use the term "DIC" for disseminated intravascular coagulation or coagulopathy. There are some conditions in obstetrics that lead to DIC, but the inability to do a partial birth abortion doesn't increase it one way or the other.

Q. Is there any correlation between DIC and abortion procedures?

A. There can be with significant hemorrhage or [p. 34] infection or amniotic fluid embolism or abruption.

Those are the – or dead fetuses. Those are probably the five most significant conditions related to DIC. But I do not believe that abortion techniques increase that incidence of any significance.

And certainly no one has ever looked at if DIC caused by the conventional techniques that we use for abortion is any higher or lower when compared with an equally manipulative procedure in the uterus, which is the partial birth abortion.

Q. Do you know what amniotic fluid embolus is?

A. Sure.

Q. And can you tell us what that is?

A. Well, it's an anaphylactic reaction. It's an allergic reaction when certain substances of the intrauterine contents are released into the maternal circulation. It's a very rare event, and it carries a very high mortality. And it can happen any time you are manipulating intrauterine cavity. So it can occur with a D & C, a D & E, cesarean section, labor and delivery. And I assume, although I've never seen any reports, that it could happen with a D & X procedure just as easily.

Q. Does the type of abortion procedure make any difference in whether or not a woman would have [p. 35] amniotic fluid embolus?

A. I don't believe so. It can occur in any of those conditions. And because it's so rare, I know of no study that would show that one technique has a higher incidence than another. All of them have that risk, including labor and delivery of a term baby at the time of normal delivery.

Q. Would it be fair to say that it's simply a complication that the treating physician has to be aware of and deal with if it arises?

A. Exactly.

Q. But the selection of the method of procedure you're saying does not enhance or increase that particular risk of amniotic fluid embolus?

A. I don't believe so.

MR. SMITH: Nothing further. I would offer Exhibits 23 and 24.

(Exhibit 24 marked.)

MR. HELLER: No objection.

(Off the record.)

EXAMINATION

BY MR. HELLER:

Q. You gave some very eloquent testimony in response to Mr. Smith's question about your experience [p. 36] prior to *Roe v. Wade*. And you talked about particularly poor women being affected by the unavailability of legal abortions. Do you recall that testimony?

A. Yes.

Q. Do you favor Medicaid funding for abortions?

A. No.

Q. Even though that might affect the ability of poor women to obtain legal abortions?

A. It may affect it. I think those of us – I'll speak for myself – that have always felt that the government should not pay for abortions basically because of the considerable diversity of opinion on the subject in this country, it is to respect those who consider abortion to be murder. And I've always felt that if common ground on this subject was ever to be achieved, it was to at least show some respect for those sincere individuals who are opposed to abortion because I don't believe they're any more wrong than I am wrong or right either. So it has always been my contention that asking their tax dollars to be used to pay for abortion was sort of a slap in their face and felt that those of us who were pro-choice needed to step up to the plate and [p. 37] contribute to those organizations that perform abortions.

And I have been espousing that for years and have lived up to that by considerable financial contribution to our Planned Parenthood here in Nashville, for example, for that very purpose. Realizing that there are problems with that, which I'm sure you could get into, I think this is the best course of action that I could come up with in trying to: A, find common ground; B, not be offensive to too many people and yet at the same time not preclude poor women from being able to obtain an abortion.

Q. From a medical perspective, however, would you concede that if in fact the lack of Medicaid funding precludes some women from obtaining legal abortions that it's medically harmful based on your experiences prior to *Roe*?

A. Well, if they don't get the abortion because they can't come up with the 2- or $300 and they go get a back alley abortion, then the answer clearly would be yes.

Q. You talked about – I think in general in your direct testimony about the need for a framework and guidance within the medical community on the abortion subject?

[p. 38] A. Yes.

Q. And I assume that applies generally to other medical issues as well?

A. Sure.

Q. Why in this arena do you believe that the general opinion of medical professionals like yourself and of the medical community as a whole is insufficient and that legislation with criminal penalties is required?

A. Interesting question. I would have hoped that the medical profession wouldn't have even brought this particular type of procedure up so as to give ammunition to those in the pro-life movement who then would use it against the movement, itself; that is the pro-choice movement.

But the fact is that there are a group of doctors in our country – and I don't know the exact number, but I know there's 37,000 obstetrician/gynecologists in this country – and I would dare say that there's more than a handful that are proponents of this procedure or perform this procedure. Maybe it's more than a handful. I don't know. But because of their performance of these procedures and because the performance of these procedures have gained public access by the television [p. 39] set, the senate floor

description, newspaper and television description, it has created a situation in this country where people have had to actually ask the question, What's going on here?

And because of that and because of what I think is a need for the medical profession to put some limitations on what we do so as to not give the impression that those of us who believe in pro-choice are extremists, I think certain guidelines need to be applied.

I would liked [sic] it to have been just a medical guideline, but since that didn't seem to work, the political arena got involved, and politics of it produced laws such as LB23 and HR1122 and Tennessee's statute which those of us who have an opinion on this matter had to take a side. I took my side, and I'm defending it this morning with you.

Q. I understand. In terms of medical guidelines developing, is it your understanding that there was an effort made to develop medical guidelines for abortion procedures in general?

A. There have been periodic attempts. We've done – we've done that locally, and I would imagine that the American College of Obstetricians and Gynecologists have at some point addressed that. I [p. 40] have never seen any written guidelines. That would have perhaps been useful years ago before partial birth abortion reared its head so to speak. But certainly here at Vanderbilt we have done that addressed the guidelines.

Q. How could you expect guidelines to develop before people know about the procedure being done?

A. Well, you can devise guidelines that take into consideration more than just procedures. You can address, A, the gestational age limits, the reasons for doing the abortion, you can accept guidelines or devise guidelines that deal with the known study procedures. For example, every procedure that I have listed earlier that I have performed, there have been research attached to that. Using that research in the safety of the procedure, guidelines come forth from that experience.

Q. Do you consider the D & E method, which was referred to in your direct testimony, a safe method of abortion?

A. I do.

Q. Does it become a different method – well, first tell me what occurs during a D & E procedure.

A. A D & E is a procedure usually done at 16 weeks, 14 to 16 weeks, occasionally 18 – and I have [p. 41] heard of them being performed as late as 20 weeks – where the cervix is dilated using the dilatation tools and instruments then placed inside the amniotic cavity to remove the fetus to – with terms such as dismemberment. These are usually done under some type of sedation and anesthesia, occasionally under general anesthesia, and often with ultrasound guidance so as to avoid complications of perforations.

Q. Would it be a significant variant of a D & E if you decided to, in dismembering the fetus, dismember the legs first and then the rest of it later? Would that constitute a new abortion procedure?

A. No. When one reaches into the cervix, into the uterus to obtain a portion of the fetus, one never knows what portion that individual is going to remove.

Q. Even with ultrasound guidance?

A. Well, you can be a little bit more specific, but it is very difficult to be able to choose, even with ultrasound guidance, what portion you're going to remove first. It is a procedure that is not done that frequently. As you know, over 90 percent are done with a first trimester D & C where that is not – that is not a D & E by any means. And of the second trimester abortion, which is 10 percent of the 1.2 million abortions, I'm not sure exactly what [p. 42] percentage of D & E versus prostaglandin or other types of techniques, but it's not that commonly performed in this country.

Q. Do you have that Exhibit 7 that we looked at before? If you would look at what's marked at the top as page 7 on this document, a chart called Percentage of Reported Legal Abortions, do you see that?

A. Yes.

MR. SMITH: Just for the record, you're referring to Exhibit 7?

MR. HELLER: Exhibit 7 from the trial or from an injunction hearing.

BY MR. HELLER:

Q. What percentage of abortions are reported as being done by labor induction from 16 to 20 weeks gestation on this chart?

A. Approximately 9 percent.

Q. So and then 86 percent are by D & E; is that right?

A. Yes.

Q. So the vast majority are done by D & E after 16 weeks?

A. Yes. My comment about uncommonly had to do with the entire number done. But as far as the [p. 43] procedure at 16 to 20 weeks, the D & E is done more often than the labor induction.

Q. About ten to one?

A. In this particular study it's about ten to one, yeah.

Q. Do you know what the source of this information is?

A. I would imagine it's CDC information that is reliable.

Q. I think the chart indicates reported by 35 states?

A. Mm-hmm.

Q. And then after 21 weeks, is labor induction the most common procedure after 21 weeks?

A. It's still the same percentage. It's 86 versus 9.

Q. So it's most common even after 21 weeks?

A. Even after 21 weeks.

Q. Does that conflict with your understanding of what was going on in the United States with abortions after 21 weeks?

A. I think it's a little higher than I would have expected, but it doesn't overly surprise me. The trend toward labor induction has increased. This was states reporting six years ago, and I think the data is [p. 44] probably different, but it doesn't change my opinion on it. I think the D & E is still a safe procedure. We're talking still about a small number that are greater than 21 weeks –

Q. A small, absolute number?

A. Right.

Q. I understand. Do you recall saying that you didn't – do you recall saying earlier this morning that you didn't think doctors really did D & E's after 20 weeks?

A. There are not many. I don't know the exact number that are greater than 21 weeks that are done.

Q. Well, I'm not talking about the whole, overall number, but it seems that of those that are done, the majority are done by D & E's?

A. That's correct, but that's still a small number of physicians that are performing them. We don't do them here in Tennessee after 20 weeks that I know of. In the Middle Tennessee area, it's usually no more than 16 to 18 weeks.

Q. Now so when you do abortions after 20 weeks here, you're using the less common method, the labor –

A. From the 1992 data, that's correct.

Q. And if someone banned that method, that would affect your practice, wouldn't it?

[p. 45] A. Sure.

Q. Talking about going back to the D & E itself, if you grabbed hold of a part of the fetus, which I assume is done with forceps, and pulled out the entire fetus in one piece, would that be a variant? Would that be a new abortion procedure or just the way it happened in that particular instance?

A. The latter. It wouldn't be a variant. It would be just something that happened.

Q. And then if you did that once – I'm using you meaning you generically, not you personally – and thought about it, would it be reasonable to conclude that by removing it in one piece, there is less risk of leaving fetal tissue behind?

A. Sure.

Q. And would it be reasonable to conclude that there's less risk of sharp fetal fragments puncturing the uterus?

A. Sure.

Q. And therefore would it be reasonable to conclude that removing the fetus intact might be safer for the woman?

A. Might be.

Q. But you'd need a good study to determine whether it really was?

[p. 46] A. I think that's a reasonable statement.

Q. Do you oppose elective abortions?

A. No.

Q. You indicated this morning I believe that sometimes you might get a woman who wanted an abortion done by D & E later when you don't do them and so you'd refer them elsewhere. Do you recall that testimony?

A. Yes.

Q. And you indicated you would refer her, among other places, to Dr. Tiller; is that right?

A. Yes.

Q. Does Dr. Tiller do abortions after viability?

A. Yes.

Q. You also testified that you consider abortions after viability immoral; isn't that right?

A. I do.

Q. When you refer to Dr. Tiller, do you feel like you're referring to an immoral doctor?

A. I explain to the patient that I am opposed to abortion after viability. Those few patients who found themselves in a situation, for a variety of reasons, with significantly malformed fetuses desiring an abortion and having explained to them that that abortion cannot be done in Nashville or Middle [p. 47] Tennessee, when they say, Isn't there anyone in this country, I admit to them that there are physicians who will perform the abortion all the way up to 36 weeks. And while I don't agree with

it and that I have a problem morally with it, I feel that it is my duty to give them the information so that they can carry out their autonomy – their autonomous – I'm at a loss for a word.

Q. Moral agency or something?

A. Thank you. Thank you. That's something that they certainly know that I don't approve of it, but I don't feel that I can not tell them about the doctors in this country that do offer that. That's part of my responsibility to let them know the options. And most of them have taken that information and used it.

Q. You testified this morning in our nonvideo deposition that the last time you've done a D & E yourself was about ten years ago?

A. Yes.

Q. Then in the second part you said at least ten years, so I'm trying to get a sense. Is it maybe more like 15 years?

A. You know, I really don't remember. 10 or 15 years when you're 57 years old sort of lumps [p. 48] together. I have helped some of my partners who do D & E's, especially when complications have arisen. But I, myself, have not taken a patient and scheduled her for a D & E and then performed it as the single provider in at least 10 years. It could even be 15. And my reasoning for that is again individual and based on my own autonomy preferences.

Q. I understand. How many D & E's have been performed with live fetuses, that is where there hasn't

been fetal demise, here at Vanderbilt Hospital as far as you know over the past ten years?

A. Probably less than 100 but a significant number.

Q. So maybe ten per year?

A. Oh, easily.

Q. Do you feel like you're in touch with advances that have occurred in the D & E method over the last 10 to 15 years?

A. Probably not. When you don't perform a procedure, you lose touch. I read the literature, but I think it's safe to say if you don't do a procedure for whatever reason, you can't consider yourself as much of an expert as someone who does them on a routine basis.

Q. What I'm trying to get at with this is it [p. 49] seems to me that – and tell me if you agree with this – that doctors operating, doing the later D & E's after 16 weeks, say, might through practice through surgical trial and error discover that they believe that it's easier, safer to remove a fetus intact, feet first with the after-coming head and then decompress the head either by crushing the skull or by removing the contents of the cranium because it involves less instrumentation and it involves less risk of fetal tissue being left over, perhaps less sharp fragments from the fetus.

Wouldn't that ordinarily – if we were putting out a picture that some people consider this another human life, wouldn't that sort of be the way that surgery evolves over time, that people try new things and feel that it works better but it isn't a big departure from what they'd done before?

A. I think you have a point. But where you lose me in the argument is if you take away the other aspects of the procedure as far as the moral and ethical precepts of the procedure, number one; and number two, something that I think needs to be addressed and I haven't mentioned it yet, and that is the effect of the procedure on, A, the individual performing the procedure; B, the nurses and other [p. 50] health care providers in the room assisting with the procedure; and C, the patient herself along with her family.

These have profound effects on the health care provider, for example. It had its effect on me with just the D & E procedure, and that's why I stopped doing those. I'm not opposed to them, but I, using my autonomy principles, decided not to do those anymore. But because I felt they were safe and because I felt that they represented a practice that was studied now and acceptable and reasonably safe that it would be a procedure that I could support in general, even though I didn't perform them, myself.

But I don't think you can remove that aspect of the effect on the health care provider and the patient, the effect on the morality issues for the public, the ethical issues for the public, from the argument that, well, if we could prove that it was safe, wouldn't it be a better technique?

I don't think all medical research should be performed without considering the ethical precepts of that study. And that's why there are human investigational committees in every hospital looking at the propriety of a study. Is it scientifically appropriate? Does it violate

informed consent? Does [p. 51] it exceed what this committee believes to be ethically and morally appropriate?

And if the answers to all those questions are no, it doesn't, they're fine, then the research can go on. But just to do a procedure and to do a small study without – formal study without peer review either before the study is begun, during the study, and then after the study, in my opinion is improper.

Q. Let me just be clear about this because my question was putting those concerns aside.

A. But how can you put those concerns aside? They're wrapped together. They're intermingled in a way that precludes them to be separate.

Q. Well, let me give you a hypothetical.

A. Okay.

Q. Suppose someone needs to have a kidney removed. And I understand you may have never removed someone's kidney; is that right?

A. Well, that's not true. I actually have, but you don't want to get into that.

Q. If someone – if in prior practice the practice had been to remove the kidney in pieces and then someone said, What are we doing it this way for? Let's remove the whole kidney in one piece because then we don't have to keep sticking the instruments in [p. 52] there, and – now, again, I'm not asking you to make the comparison. I'm asking you to tell me whether you think it would be reasonable from the standpoint of the patient's health to

make the assumption that that procedure in which the entire kidney is removed at once may somewhat be safer.

A. Well, I would turn it around. Anyone who knows anything about medicine, – and I don't mean to demean your knowledge of medicine because you were trained in the law and I was trained in medicine – it would be much safer to remove a kidney in whole than it would be in parts because as you start to chip away at the kidney, you start getting into bleeding.

The mother then or the father or the human that you're doing that would bleed to death. So anyone who knows anything about medicine would first say, Let's take it out whole. If you turn the argument around somehow – and it would be very hypothetical – that taking it out in whole has been the practice and somebody thought, Let's take it out piece by piece, then at least it makes more sense although I could hardly enjoin that argument because I know it would not be. You're equating a kidney with a fetus.

Q. I wasn't trying to –

A. No, but you do. If you want to make a [p. 53] hypothetical, it's just not a good hypothetical. I might could help you with something else with a different kind, but that's just not good because taking out a kidney piece by piece would more than certainly kill a large number of humans, and taking it out whole would make the most sense.

Q. I understand your objection to my hypothetical.

A. Okay, thank you.

Q. Let's get back to the situation we're talking about. Let's talk about a D & E versus what I'm going to call an intact D & E which is where you remove the fetus intact.

A. Okay.

Q. Is it your understanding that the Nebraska legislation prohibits intact D & E?

A. As I read it I believe that to be true, yes.

Q. And do you consider the intact D & E vastly, morally – let me say do you consider the intact D & E more morally objectionable than a D & E in which the fetus is dismembered?

A. Well, now that's a very good question because I've had to deal with that, and I don't – I do see a difference. I'm troubled by the D & E, intact or [p. 54] otherwise. But I am willing to admit that the intact D & E has caused a considerable dilemma for all sides of the matter on abortion, pro-choice, pro life, and the public in between. I have a problem with both.

But because D & E, assuming that it's done before viability and with the proper techniques, I believe has been proven to be safe and therefore is a technique that should not be banned as partial birth abortion has been banned.

Q. Well, but isn't the intact D & E just a variation of the D & E?

A. It is a variation, assuming that it's done before viability, as you know –

Q. Yeah, I'm talking about before viability.

A. I believe it is a variation of it, but that's not the issue that was before the American public. And the D & E did not come before the American public in the same way that the intact D & E or the D & X did. And so we're dealing with the D & X. What society wants to eventually do with the D & E at some point is hard to guess.

And those of us who work in this field will have to address that issue when it arises, if and when it arises. But certainly at this point I don't have a problem with states setting certain limitations, [p. 55] especially if they're not unduly burdensome. Removing this shows responsibility of the state and shows some commitment to allowing for limitations that would not erode maternal health or the health of women having abortion and at the same time placate some of the severe criticisms of those individuals who are performing the procedure.

Q. That made me think of a lot of questions.

A. Okay.

Q. Do you think if these statutes were all upheld, the opponents of abortion would be placated and just say, Okay, we're done?

A. Oh, no. And as a matter of fact, I've told my pro-life friends who have used some of my attitudes to their benefit that once we change the viability definition in Tennessee that I think they have lost me as anyone that would support the arguments. I think gestational age limits and types of procedures are things I'm interested in.

But I want in no way to erode further the ability of women to obtain a safe abortion. And that would include all the procedures that we've talked about other than the intact D & X.

Q. Would you favor banning the D & E abortion?

A. No, I would not favor it.

[p. 56] Q. You testified that you were – part of your support for this legislation is because there are safe alternatives available; is that correct?

A. Yes.

Q. Do you know if there are safe alternatives available in Nebraska?

A. I've never practiced in Nebraska, so there's no way for me to know. However, using the definition of geographical standard of care and knowing that our colleagues pretty much practice reasonably similar approaches to medicine, I have no reason to think that it would be any different in Nebraska as it is say here in Tennessee.

Q. Well, hypothetically if it turned out that there were no hospitals in Nebraska, unlike Vanderbilt, where a woman could obtain an elective abortion at any stage of pregnancy, would that change your opinion about the availability of alternatives?

A. Oh, no. I'm aware of the fact that 84 percent of the counties in the United States do not have abortion services. I am very aware of the decreasing number of abortionists in this country. Only a small percentage of – I think a third of the residents that we train even get any

training in abortion. I'm aware of the inequities of the services [p. 57] that are available.

Having said that, that doesn't allow me then to take that and have it be a reasonable argument against the moral and ethical precepts of this particular procedure of an intact D & E.

Q. I want to ask you a different sort of question. The plaintiff in this case is a man named Dr. Leroy Carhart. And there's been testimony that he performs several different procedures, depending on gestational age of the fetus, and that he attempts to remove a fetus intact during the D & E procedure and that he believes that's safer for the women he treats.

To what extent does your opinion about the availability of safe alternatives – to what extent is that affected by the doctor's own assessment of what he or she is best skilled at? In other words, if someone said to you, No more prostaglandin inductions, you've got to do only D & E's from now on, would you stop doing abortions? Let me ask that first.

A. I might. I might.

Q. Wouldn't that then affect women's access to abortions?

A. It might. I'm not a sole provider of abortions in the state of Tennessee, and I would imagine your plaintiff is not the sole provider of [p. 58] abortions in the state of Nebraska.

Q. Well, actually there's testimony that he is the sole provider after 16 weeks of pregnancy.

A. Well, I maintain that those arguments, while valid, do not reach the level of significance that overrides the other issues that I've already enumerated on a number of times.

Q. And if I understand that issue correctly, it's that you believe that intact removal of a fetus during a D & E is more morally objectionable than dismemberment. I'm trying to get a sense –

A. No, I understand. You're asking the right questions, and I appreciate what you're doing. But I don't think it's just a matter of intact removal as opposed to dismemberment. I think you're talking about more than just intact removal because what you often have is a fetus that is dangling nine-tenths of the body outside the vagina with legs and arms frailing (sic) and then a stiffening up when the trocar is put into the base of the brain to suck out the intracranial contents.

Q. Excuse me. What do you base that on?

A. The description of numerous sources of those who have written about the procedure and witnessed the procedure.

[p. 59] Q. In medical journals?

A. In a variety of journals but not medical journals.

Q. In the press?

A. I read them in the press. I have read testimony by nurses. I have read in the New York Times magazine by reporters.

Q. Are those the sorts of sources you would ordinarily –

A. Well –

Q. Let me finish – you would ordinarily rely on to form your medical opinions?

A. Oh, of course not. On the other hand –

Q. Well, that's important.

A. I'm not going to go view such a procedure just so that I can find out whether what I read in other journals is true or not.

Q. I understand. I'm just trying to get a sense of what you base your conclusions on. But you said nine-tenths of the fetus or baby is dangling outside the vagina?

A. Sure.

Q. Is it your understanding that there's a requirement in the law that the fetus be outside the vagina? Couldn't it be in the vagina?

[p. 60] A. It could be. What happens is usually as the fetus is delivered, a significant portion – maybe I misspoke myself with the use of 90 percent. A significant portion of the fetus is outside of the vagina. Otherwise, it's difficult to put a – I would imagine it was difficult to put a needle or trocar through the base of the skull underneath the cervical realm.

Q. Is it correct that the reason to do that, to insert the trocar would be to reduce the size of the head so it could come through the cervix?

A. Exactly.

Q. Now how do you get the head of a fetus out in a regular D & E if it doesn't fit?

A. Well, usually the skull is the last portion of the fetus to be brought through the birth canal, and it is usually after the fetus is dead obviously. Instruments are used to grab the fetal skull, and it literally crushes the bone to bring it through the cervical canal.

Q. And you find there to be a significant moral difference between doing that and a standard D & E and doing it when there is this dangling significant portion?

A. In the partial birth abortion the fetus is [p. 61] alive. In the crushing of the skull to remove the fetus in the D & E, the fetus is not alive.

Q. Well, let's get to the question of what – and we talked about this earlier this morning. The Nebraska statute uses the term "substantial portion," and you testified earlier that you consider that to be something more than a hand or a leg; is that right?

A. Right.

Q. But you also concede that some people might consider a hand or a leg to be a substantial portion?

A. I'd concede it that way.

Q. And that in fact in an ordinary D & E, a leg could be removed and the remainder of the fetus could still be alive for a brief moment?

A. Correct.

Q. And that if the broader definition of "substantial portion" were adopted that D & E's could be prohibited by Nebraska law?

MR. SMITH: I'm just going to object just because of your terminology, the broader definition, I don't thick [sic] it's clear what you meant.

BY MR. HELLER:

Q. Oh, absolutely. The definition of substantial portion there would include a hand or a foot or a leg or an arm. But if that definition is the [p. 62] one, then D & E's could be prohibited by the Nebraska law?

A. Anything is possible. I just don't know – it can't reach the level of probability for me because it's never been tested.

Q. What I'm asking is if the Nebraska legislature had said "substantial portion" means a head, an arm, a leg, a foot, a hand, then we would have some clear idea of what it means, right?

A. I doubt that I would thence be able to support the Nebraska bill if it had gone that far to describe that. We had the same problem in Tennessee, and it was my reliance on the terminology of "substantial" that allowed me then to support the bill because I had no desire to outlaw – while I may disagree with the D & E, I in no way wanted to outlaw the procedure itself.

Q. Well, let me give you another hypothetical. Do you currently – you indicated you use prostaglandin induction methods for abortions here?

A. Yes.

Q. Suppose Tennessee passed new legislation and it said that no prostaglandin abortion may take place if the procedure lasts for a substantial period of time. That was

all they said. And they would – if [p. 63] you – if the procedure did last a substantial period of time, you would end up facing felony penalties here in Tennessee. Would you have concern that the various possible meanings people could ascribe to the phrase "substantial period of time" would put you at risk for prosecution?

A. Well, without getting into all the objections to the hypothetical, I think the answer would be yes.

Q. And if you were doing D & E's, wouldn't you be concerned that maybe you would – maybe you are removing a substantial portion because it's not defined within the statute and you might go to jail for doing that? If someone later on said it does include a leg?

A. I understand that any bill that tries to be exact has a certain element of vagueness, and I am willing to accept that for the greater good of developing moral frameworks of the process of abortion. But I can't argue with you that these vague – some of these terms that are considered vague can be defined differently. And "substantial" obviously is an important word.

I'm hoping that once these laws are passed that the procedure of D & X or intact D & E will not be performed and that no doctor will be prosecuted for [p. 64] doing a D & E where a portion – a substantial portion is considered a small anatomical part of the fetus.

Q. Have you seen any documents from the sponsor of the federal bill indicating that he didn't believe that the federal bill applied only to D & X abortions?

A. Yes. Well, the original bill at the federal level clearly involves D & E.

Q. I mean the more recent version that was vetoed by the President?

A. Yes, it included D & E as far as I can tell.

(Off the record.)

BY MR. HELLER:

Q. What sort of documents, if any, did you review before today's testimony?

A. Nothing really. Counsel showed me the Nebraska statute which I had already seen, the ACOG bulletin stating the policy right before deposition again which I knew about and have seen and read, and the AMA's Exhibit Number 7 that I had also seen and read before.

Q. You didn't review any of the legislative history under Nebraska law?

A. No.

[p. 65] Q. You had looked at the ACOG statement, which is Exhibit 24, earlier and you testified about that and about some of the language in there. Would you agree that someone at ACOG, some people believe that the D & X procedure may be the most appropriate procedure in some instances?

A. I do.

Q. And so at a minimum there's a division of medical opinion about whether it's an appropriate procedure or not?

A. Sure.

Q. And there was a similar statement in Exhibit 7 that you looked at from the AMA, a statement about it being an appropriate procedure or perhaps safer because it reduces trauma. Do you agree that it may be safer because it reduces trauma?

A. Well, "may" is a very big – allows for a lot of leeway, so if there's no studies to show, of course, it's theoretically possible and therefore may.

Q. But before there are studies, people go based on their general surgical experience, wouldn't they, in making modifications to a surgical technique?

A. Well, that's true. But again, I said it's hard to – it's hard to dissect or separate the other issues with this particular procedure, not only the [p. 66] moral and ethical precepts which I've outlined, but the public reaction to it and the ramification. Already in this country we have seen, because of the controversy of D & X, that there has been a significant drop in public support for abortion.

So the pro-life movement has clearly done an outstanding job of public relation-wise by putting this D & X procedure up before the American people, has been aided by the pro-choice movement which refuses to address the moral and ethical framework of the procedure of abortion and therefore has eroded the support that I think pro-choice movement needs to maintain.

And so it's my firm belief that had the pro-choice movement and the medical profession said, Of course, this is something we shouldn't do, the issue would have been dropped and that public support wouldn't have

dropped 8 percent which it has been just recently shown to have been dropped.

Therefore, I persist despite the fact that some of the arguments you make are reasonable. And while some of my arguments are not totally without some flaw and some inconsistencies, I believe that what Nebraska has done and what Tennessee has done and what a number of other states have done with that particular [p. 67] wording comes about as close as we can hope for in demonstrating to the public that the medical profession and the states are willing to state certain moral and ethic frameworks of how we offer and administer the process of abortion.

Q. I was provided with – it's a faxed version of a letter signed by you, addressed to a Dr. Levine or Levine, Mark Levine. Do you recall that letter?

A. Yes.

MR. HELLER: Does that – and actually I guess I could get it marked.

(Exhibit 25 marked.)

BY MR. HELLER:

Q. Do you recall that letter?

A. Sure.

Q. And does it accurately summarize some of your views about partial birth legislation?

A. Yes.

Q. On page 2 of that letter you state – you wrote at the very bottom, "It is my opinion that such a procedure

should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists."

A. Yes.

Q. Is that still your view?

[p. 68] A. Yes.

Q. And do you think that's a significant basis for your support for this legislation?

A. Yes. Significant or substantial?

Q. I'll leave that to you. If you don't feel comfortable with the word "significant", we can use a different word.

A. No, I'm comfortable.

Q. No one goes to jail here if you use the wrong word or if I do.

A. I'm comfortable.

Q. Okay. I want to go briefly back to the woman who wants an abortion at 22 weeks. And let's assume that what you understand to be partial birth abortions are not prohibited, so she can choose – and that she's in a state with a lot of abortion providers. So she could choose a prostaglandin induction procedure. She could choose a standard D & E involving dismemberment. She could choose an intact D & E. She could even go to someone who will do the exact procedure in the ACOG definition involving conversion of the fetus, if necessary.

What in your view from a medical standpoint – and I want to talk about safe – if you could talk about physical

safety risks. What do you [p. 69] believe justifies the State in prohibiting one of those options and not all the others or picking one out and saying, This one we're prohibiting; the others, go right ahead, to the woman?

A. Well, I believe you've gotten my response on that because if you would have asked me that question, whether there's any difference that we know of in medical complication rates or injury to the mother, we really don't. They would all be acceptable medically. But as my letter indicates and I have stated many times before, the other procedures are not before the American public.

The other procedures have not reached the level of concern by lawmakers, by the general public, and by the medical profession. And so with that particular aspect in place, it's reasonable for the State to respond to the fear and concern of the public and the health care providers who are severely or significantly opposed to this type of procedure to ban it.

The corollary would be to say that the State has no right to ban any procedure that the public believes to be immoral and unethical and disgusting. If our society continues with doing anything it wants, eventually all abortions may be eliminated. And that [p. 70] will come about because the American population has made up its mind that abortion is wrong, regardless of the reason and regardless of the technique, and *Roe v. Wade* will be overturned. That will be a public domain. That will be a public phenomenon that will not be brought about by individuals such as me.

My role is to try to defuse the fervor so that Americans and the 70 percent who believe that abortion should

be kept legal, safe, and rare will maintain to be the majority so that *Roe v. Wade* will not be overturned and the majority of women will still be able to obtain a safe and facile and accepted abortion.

Q. But all of that is in essence, isn't it, your personal opinion, your political opinion?

A. Well, of course, absolutely. You're getting nothing but Frank Boehm here. You're not getting anybody else.

Q. Okay. This morning we spoke briefly about the lack of a statistical study on say the intact D & E variant of the D & E, and you said you didn't know of such a study; is that right?

A. That's correct.

Q. And didn't you also concede though that if the procedure is banned, there is unlikely to ever be [p. 71] such a study, at least in the United States?

A. Right.

Q. So we might never know if it's even 3 percent safer?

A. Might never know.

Q. And women might be deprived of a procedure that's 3 percent safer and they would never know that they were deprived of it; is that right?

A. That's correct.

Q. Even when used pre-viability?

A. Correct.

Q. You also testified earlier about doing terminations of pregnancy after 24 weeks, but you don't call them abortions; is that right?

A. That's correct.

Q. And you do those procedures in cases of lethal fetal anomalies?

A. Sure. The definition of an abortion is the delivery of a fetus with the intent to deliver a dead fetus. If our intention is not to deliver a dead fetus, then it's not an abortion. It's just a termination of pregnancy. And if the diagnosis is a lethal one such as renal agenesis or anencephaly, then the fetus dies during the delivery process or immediately thereafter.

[p. 72] This is not an abortion. This is a delivery so as to help the psychological aspects of a woman knowing she's carrying a fetus that will not survive as well as reducing some of the complications of allowing a pregnancy to continue.

Q. You also testified that you thought one reason justifying the partial birth abortion ban was the possible effect on the emotional health or moral health of nurses, providers, and the women themselves. But you have no statistical or even anecdotal support for that, do you?

A. Only in what I've read in the lay press and journals, nonmedical journals, and my experience with health care providers who participate in a procedure that is not banned but has certain elements of unpleasantness such as the D & E.

Q. But just to be clear, that's not really your expert opinion as a medical expert, is it?

A. No, not at all.

Q. And – almost done. You indicated that you teach abortion techniques here?

A. Yes.

Q. Which techniques do you teach?

A. The suction D & C, the sharp D & C, the prostaglandin abortion, and the hysterotomy and the D & [p. 73] E. I don't personally teach D & E, but my partners do.

Q. And is it you don't teach the D & E because to some extent you find it offensive?

A. I don't perform the D & E, so I can't teach something I don't perform. If one of my partners needs some help, I'll be there to help during a process of complication. But they don't have the same problem I do, so they perform them and I don't.

Q. When you – shortly after *Roe v. Wade* when a woman would want a second trimester procedure say at 14 weeks, what procedure was used?

A. A D & E.

Q. What about at 16 weeks?

A. Usually we went to saline abortions or intraamniotic prostaglandin or intraamniotic glucose.

Q. Do you do saline abortions now?

A. No.

Q. Why is that?

A. We have better techniques and techniques that are not associated with as high an incidence of problems

such as coagulopathy and saline – inadvertent intravascular injection of saline which has resulted in maternal deaths. Complication rates I think is the biggest – also the concern of the burn of the fetal skin over a period of time and the perception of pain [p. 74] problems. I think the prostaglandin allowed us to move away from those procedures and move toward a procedure that more of us who were pro-choice felt we could live with.

Q. And in addition, one that was perceived to be safer or is safer?

A. Good question. I don't think anyone has compared saline with intravaginal prostaglandin which is what's used today, but I would think it's safer from what – this would be anecdotal experience over years of performing both, that the saline was not as safe as the intravaginal prostaglandin procedure.

Q. So in that case even though there might not be statistical studies, you felt comfortable making that transition?

A. I did, yes.

Q. And also there was a transition, wasn't there, to doing more – to doing D & E's later in pregnancy than initially they were done?

A. Yes.

Q. And if someone at that point had banned D & E's, we wouldn't know today whether that method was safe or not safe; is that right?

A. That's true.

[p. 75] Q. If a woman – going back to the example of the woman facing the various options for a 20- or 22-week abortion wants to weigh the risks and benefits of each procedure as part of her informed consent process, to what extent does removing one option interfere with her informed consent?

A. I think if they have reasonably safe options that it doesn't interfere with it at all.

Q. I'm sorry. Does not?

A. Does not interfere.

Q. So that a woman who says, Well, I'd rather not have a 12-hour period of contractions and cramps. I'd rather have a D & E. If the D & E were the banned procedure, it doesn't affect her informed consent not to have that other option, even though the other one –

A. It doesn't affect her informed consent. First of all, the D & E is not what we're discussing. We're talking about the D & X. And hypothetically we have no discussion on the table to remove the D & E. But I think that when women get to the point where they're 20 weeks pregnant or 22 weeks pregnant, assuming that for whatever reason that the abortion is being planned, this is not a perfect world and we can't offer perfect solutions to make everyone happy and to do this quickly and without any emotional distress.

[p. 76] Whether it's 12 hours or 24 hours or occasionally 36 or 48 that we've had to use to effect abortion with prostaglandin, I don't think it's fair to try to compare the procedures and say because one is a shorter or one appears to be quicker that one is superior to the

other. They're all difficult for patient and health care provider alike to undergo. And removing the D & X in my opinion doesn't inhibit a safe alternative.

Q. But removing the D & E would?

A. At this point I believe that it would, yes.

Q. And wouldn't also removing the D & E interfere with the woman's choice method?

A. Probably.

Q. Just like you can decide to get – a doctor can present you with chemotherapy for cancer and radiation therapy and tell you the advantages and disadvantages of both and the patient chooses?

A. I think that's reasonable to state, yes.

Q. Okay. I brought that up because of your background you indicated in medical ethics, and I think that's –

A. Sure.

Q. – an aspect of this if we – you know if we look at just the choice of method.

[p. 77] (Off-the-record comment.)

BY MR. HELLER:

Q. You indicated that you believe the choice, the abortion choice needs some limitations?

A. Yes.

Q. And indicated that this is one of those limitations that you support. Can you tell me, are there any others you support?

A. Yes.

Q. What are they?

A. I support one-parent consent in minors with a judicial bypass procedure in place. I support a 24-hour waiting period from counseling to procedure. I support gestational age limits, not to be performed once 24 weeks has been achieved. I support private funding for the poor rather than government funding for abortions. And I obviously support certain procedures such as partial birth abortion bans. But that's it.

Q. Do you recall signing a sworn statement that a three-day waiting period in – sorry. I have the wrong ending to this. One second, please. I'm sorry. I had the right one. Do you recall signing a sworn statement submitted in Circuit Court of Davidson County in Tennessee in 1992? I'll quote and you can tell me if [p. 78] you remember: "The three-day waiting period mandated by the statute provides no benefit to a woman seeking abortion."

A. I'm sorry. Could you read it again?

Q. Sure. "The three-day waiting period mandated by the statute provides no benefit to a woman seeking an abortion and will only make obtaining abortions more difficult and expensive, especially for poor women who may have traveled to Nashville from rural areas in order to obtain an abortion." In addition, in many cases this waiting period requirement will prevent women from obtaining abortions at all. For these women waiting the three days prescribed by the statute will take them past the term of pregnancy 14 weeks LMP, during which

Planned Parenthood will perform an abortion. Abortions after this period are unavailable in Nashville for women with healthy fetuses. Do you recall –

A. Oh, yes, and there's a big difference between 72 hours and 24 hours.

Q. So you support 24 hours?

A. I have decided that I can support 24 hours.

Q. I could not support more than 24 hours.

Q. Do you support a requirement that abortions after the first trimester of pregnancy be performed in [p. 79] a hospital?

A. After what gestational –

Q. After the first three months of pregnancy?

A. No. I think you can go up to about 14 weeks safely in an outpatient clinic. That's just a couple of weeks different. It depends on how you define first trimester. I define it as to include 14 weeks.

Q. But after 14 weeks it should be done in a hospital?

A. I believe that to be true.

Q. And you support a statute that would say that?

A. I don't have a problem with a statute that supports that.

Q. Do you support a requirement that physicians provide informed consent for abortions personally?

A. Yes.

Q. Did you support that in 1992?

A. Well, you didn't give me an alternative, I guess. I think a physician should obtain the informed consent. I also am aware that a lot of informed consent initiates from other health care providers. But I believe a physician should at some point in the [p. 80] process before doing it, should sit down and talk to the patient.

MR. HELLER: Can you mark this as Exhibit 26?

(Exhibit 26 marked.)

BY MR. HELLER:

Q. Can you take a look at it and tell me if you remember this? I apologize for the pages going over two pages. I think they were originally eight and a half by fourteen pages.

A. I remember this.

Q. If you want, just check the last page. Is that your signature on the second-to-last page?

A. Yes, that's mine.

Q. This was your sworn statement back in 1992?

A. Yes.

Q. Have your views changed?

A. I don't know. I need to read it again. Can I get a copy too?

MR. HELLER: Sure. I think I'm done except I want to move the admission of 25 and 26. You may want to look at 26.

MR. SMITH: No objection.

(Off the record.)

[p. 81] REEXAMINATION

BY MR. SMITH:

Q. Exhibit 25, which is a letter you wrote to Dr. Levine, you wouldn't have been under oath obviously at the time you wrote that. But as you sit here under oath now, do you adopt all of the opinions and the statements in there as being true?

A. Yes.

MR. SMITH: Okay. Nothing further.

(Deposition ended at 1:15 p.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 32

DEPOSITION OF
FRANK HENRY BOEHM, M.D.
Friday, January 23, 1998

* * *

[p. 2] The deposition of FRANK HENRY BOEHM, M.D., was taken by counsel for the Plaintiff at the offices of Dr. Boehm, Vanderbilt University Hospital, B-100 Medical Center North, Nashville, Tennessee, on Friday, January 23, 1998, beginning at approximately 10:40 a.m., for all purposes allowed under the Federal Rules of Civil Procedure.

It is agreed that Carol A. Nichols, Registered Diplomate Reporter, Certified Shorthand Reporter, and Notary Public for the State of Tennessee at Large, may swear the witness, take the deposition, and afterwards reduce same to typewritten form, and that the reading and signing of the completed deposition by the witness is waived.

All formalities as to caption, certificate, transmission, filing, et cetera, are waived. All objections except as to the form of the questions are reserved to on or before the hearing.

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EXHIBITS

(None offered.)

[p. 3] *Frank Henry Boehm, M.D.*, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HELLER:

Q. Would you please state your name for the record?

A. Frank Henry Boehm.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. So you're familiar with the process?

A. I am.

Q. How are you currently employed?

A. I am employed by Vanderbilt Medical Center.

Q. How long have you been with Vanderbilt?

A. 25 years.

Q. In what capacity are you employed by Vanderbilt?

A. I am Professor of Obstetrics and Gynecology in the medical school, and I am Director of Obstetrics for the hospital.

Q. Where are you licensed to practice medicine?

[p. 4] A. The state of Tennessee.

Q. And do you have any board certification?

A. I'm board certified in obstetrics and gynecology and in maternal-fetal medicine.

Q. Just this morning Mr. Smith gave me a copy of your curriculum vitae which has been marked as Trial Exhibit Number 23, and I just wanted to ask you if that's accurate and fairly current?

A. It is.

Q. Thank you. Have you given testimony before in court?

A. I have.

Q. On what occasions?

A. Since 1981, I have served as a medical-legal expert consultant and I have – I go to trial somewhere around three to four times a year.

Q. In what locations?

A. All over the country.

Q. Have you testified in federal court?

A. I have.

Q. Do you typically testify as an expert in those cases?

A. Yes.

Q. And is your testimony typically offered on behalf of a plaintiff or defendant or either?

[p. 5] A. Either. Most of it has been defense, but in trial I have – in the last four years I have been to trial fifteen times, two for the plaintiff and thirteen for the defense.

Q. Have you testified in any criminal cases?

A. No.

Q. Have you previously testified in a case involving the constitutionality of a state statute?

A. No.

Q. Have the cases you've testified in been primarily malpractice cases?

A. Yeah. 100 percent of them have been malpractice cases.

Q. Okay. How did you become involved in this case?

A. A phone call from Jim Smith's office in Nebraska asking whether I would be willing to serve as a consultant or to do a deposition or to testify on behalf of the State of Nebraska.

Q. And you agreed to do that; is that right?

A. I did, yes.

Q. Are you being paid a fee to testify?

A. No.

Q. You're doing this without charging any fee to the State of Nebraska; is that correct?

[p. 6] A. If I have to go to Nebraska to testify at trial, I would charge the State for my expenses, flight and hotel and food. But other than that, I'm not charging anything.

Q. Have you been approached by any other entities to testify either for or against the constitutionality of state statutes?

A. Yes.

Q. Can you tell me about that? In other words, who has approached you?

A. I have received phone calls from the Attorney General's office in the states of Alaska, Rhode Island, Arkansas, and Georgia.

Q. Have you agreed to testify in any of those cases?

A. I have.

Q. In which ones?

A. All of them.

Q. Have you submitted any written affidavits in any of those cases or written sworn statements?

A. I believe I have in one case, but I'd have to check my records. I can't remember which one, and I'm not even that sure that I did. My memory allows me to say to you I think I have in one case.

Q. And are those cases you mentioned, Alaska, [p. 7] Arkansas, Rhode Island, –

A. And Georgia.

Q. – and Georgia, are they all involving partial birth abortion statutes?

A. Exactly.

Q. Have you – are you charging a fee in any of those cases?

A. No.

Q. Is it a similar arrangement where if you had to go out to that state to testify, you'd ask for your expenses to be covered?

A. Yes.

Q. And you haven't ended up testifying so far in any of those cases?

A. This is my first.

Q. Prior to this deposition today, have you given testimony in a case involving abortion? In other words, were any of the malpractice cases involving abortion?

A. Yes.

Q. In what respect was an abortion involved in any of your prior testimony?

A. Well, I can only remember one case, and it was a wrongful death case where abortion was induced with an error in diagnosis. But it did involve [p. 8] abortion, but the issue was wrongful death rather than abortion.

Q. Do you recall what state that was in?

A. It was in the state of Alabama.

Q. And on what side were you testifying in that case?

A. For the defense of the doctor being accused of making a wrong diagnosis.

Q. I see. Have you published any articles about abortion?

A. Yes.

Q. Is it possible for you, looking at your CV, to identify any of those for me if you look through it?

A. The yes came more from published in a newspaper column that I have that I write for two newspapers in Nashville and in Florida.

Q. Okay.

A. That is published. But scientific publication, there may be one or two in here. Let me see. Yes. Paper number 47 entitled "Induced Abortion: A Risk Factor for Placenta Previa."

Q. Okay. Thank you.

A. Article 98 is entitled, "Wrongful Life and Wrongful Birth." I don't know if that addresses abortion. I haven't read it since 1989, but I'll [p. 9] mention it for completion's sake.

Q. Okay.

A. That's it.

Q. Okay. Thank you. Do you consider yourself an expert on the statistical safety of different abortion methods?

A. Sure.

Q. And have you, yourself, done research in that area?

A. No.

Q. Do you currently perform abortions in your medical practice?

A. Yes.

Q. How long have you been performing abortions?

A. Since my residency in the 1960's.

Q. Approximately how many abortions would you say you performed in the last year?

A. This is like a Dr. Henry Foster question.

Q. No.

A. Oh, Lord. I really don't know. It's not that many. The abortions that I do at Vanderbilt are usually second trimester abortions for congenital anomalies or serious problems that affect mother's health or well-being, most of them being anomalies. [p. 10] And I usually help the residents with these cases. Perhaps somewhere between a half a dozen to a dozen I've been involved in. But I really don't have an exact number.

Q. Would you say over the course of your career you've done more than 100 abortions?

A. Oh, sure.

Q. More than 1,000? I'm not trying to pin you down. I'm just trying to get a rough idea.

A. More than 1,000? Probably not more than 1,000.

Q. So somewhere in between 100 and 1,000?

A. That sounds reasonable.

Q. And what's the earliest in gestational age that you've done an abortion?

A. Oh, somewhere around six or eight weeks of pregnancy.

Q. And what would be the latest in gestational age?

A. 22 weeks.

Q. And when you say 22 weeks, do you mean from the woman's last menstrual period?

A. I do.

Q. At what point do you consider fetal viability to occur?

[p. 11] A. 24 weeks.

Q. Do you believe that 24 weeks is sort of a hard and fast rule or varies depending on the particular pregnancy?

A. No, I think it's a reasonably hard and fast rule.

Q. What abortion methods have you used during the past year?

A. During the past year I've used the prostaglandin-induced labor, induced abortion technique.

Q. Any other methods?

A. No.

Q. Have you ever used the dilation and evacuation abortion method?

A. D & E, I have.

Q. When was the last time you used that method?

A. Oh, maybe three years ago.

Q. And were you terminating a pregnancy where there was a live fetus at the beginning of the procedure?

A. I was assisting one of my partners with the evacuation of a live fetus, yes.

Q. During the course of your career, could you [p. 12] estimate out of the 100 to 1,000 abortions roughly what proportion were D & E's?

A. Small proportion, less than 5 percent.

Q. So if it's less than 5 percent, it's somewhere between 5 and 50 we could say?

A. That sounds about reasonable.

Q. And what proportion have been inductions using prostaglandin or other drugs or saline?

A. Ever since I started doing these?

Q. Yeah. Of the entire number you've done, how many have been by induction?

A. I would say 75 percent have been by induction and the other 25 have been first trimester abortions with the simple suction curettage or D & C.

Q. Have you performed abortions exclusively – let's say within the last 25 years, exclusively here at the hospital?

A. Yes.

Q. Do you recall writing an article for The Tennessean newspaper entitled "Doing the Right Thing for the Right Reasons"?

A. Yes.

Q. Is it your view that after viability in a case where the life or health of a mother is in jeopardy and her fetus has reached a reasonable chance [p. 13] of survival outside the womb that physicians can deliver the child by either cesarean section or induction of labor without compromising the mother?

A. Yes.

Q. Do I understand then that it's your view that a c-section doesn't compromise the woman's health as opposed to a D & E?

A. It depends on the relativity of the discussion. So if you bring it up, cesarean section versus D & E, the cesarean section would be more – would increase the risk of morbidity to the mother than the D & E.

Q. Also mortality; isn't that right?

A. Probably mortality. Although the numbers are small, there probably would be a slight increase in cesarean section over D & E. But those studies have never really been done to compare the two. But from background, training, and experience, I would agree with you that it would increase morbidity and mortality over D & E.

Q. And what would be the reason not to do a D & E after viability?

A. Well, that's 24 weeks. That's a very large fetus to be dismembering vaginally. Forgetting, the ethical principles and moral principles, putting that [p. 14] aside for a moment which I'm sure we'll get into, I don't know of anyone that performs D & E's at 24 weeks. That is an incredible experience. Even the most ardent advocates of D & E's stop somewhere around 18 weeks, perhaps 19 or 20 in a pinch so to speak. But I know of no one that would offer a D & E at 24 weeks.

Q. Let's assume for a moment that we're talking about a situation where there has been fetal demise at 26 weeks.

A. Right.

Q. Would you deliver the dead fetus by cesarean section?

A. Oh, no. That would then include either prostaglandin or D & E. When I said – my earlier comments on D & E was on a living fetus. But sometimes when a fetus has been dead for a while, it becomes emaciated and it's easier to remove vaginally. But even in those cases, we would use prostaglandin and not a D & E. The fetus is just too big at that stage to be taking it out piece by piece.

Q. And you're aware of no one in your profession who performs D & E's after 24 weeks?

A. Never heard it done, never seen anyone do it, never read about anyone doing it. While anything is possible in this country, I would never recommend [p. 15] such a procedure and have never seen anyone or heard of anyone doing that.

Q. And what about at 22 weeks? Have you heard of people doing D & E's at 22 weeks?

A. In dead fetuses, yes. But again up to 20 weeks has been as far as I've ever seen anyone advocate a D & E, and most of the people that I know that do them routinely stop somewhere around 18 weeks.

Q. Would that be different if you induced fetal demise by digoxin at 22 weeks? Would that change whether you should or shouldn't do a D & E?

A. Well, there are two reasons that a physician may not want to do a D & E. One is the procedure itself is somewhat aesthetically unpleasant, especially on a live fetus. So first performing a procedure that would result in fetal death, such as a cardiac injection of potassium chloride, would make that more palatable.

The other is the technique itself. It's not easy to dilate a cervix large enough to get a head through at that gestational age. But I don't think that I'm in a position to say that doctors have never done that or don't do that in this country. I'm just not aware of them.

Q. Of the two procedures, putting aside the [p. 16] c-section for a moment, let's say at 20 weeks or 19 weeks if you could do either a D & E with a live fetus or a prostaglandin-induced delivery, which would you say is more debilitating or disabling for the woman, which of those two procedures?

A. Well, the data indicates that it's morbidity-wise slightly safer for a D & E in experienced hands as opposed to prostaglandin. Having said that, I don't know of any side-by-side studies that prove that although I

don't argue with that. But at Vanderbilt for the last 25 years, we have used labor induction technology. And in the last few years the use of Cytotec, which is a prostaglandin product compound, is so effective that I would love to see some studies that compare Cytotec-induced abortions with D & E's to see if that safety factor still holds true.

Some of the older studies were done with intraamniotic saline and intraamniotic prostaglandin, and in those cases it was clear that the D & E was safer. But I don't know of any studies that compare the D & E at 18 weeks, 20 weeks let's say, with Cytotec or the prostaglandin gels that are now readily used for abortion.

So the older data would support your premise or the premise that D & E's might have less [p. 17] morbidity, but I don't know if that can still be said for the newer compounds.

Q. I just have a few more questions. What I was driving at was something slightly different. Let me approach it this way. How long a procedure is the prostaglandin induction procedure?

A. We tell patients it's approximately 24 hours.

Q. And during that 24 hours, what does the woman experience?

A. Contractions, cramps which we give epidurals for to reduce discomfort. They're in a labor bed. They have an intravenous going, running. We administer the prostaglandin intravaginally and wait for contractions, give them pain relief, and then they deliver usually within 24 hours the fetus and placenta and are sent home.

Q. And the D & E at 20 weeks, how long a procedure is that?

A. Well, we just don't do them at 20 weeks. But having seen them let's say at 16 weeks – I could speak from experience – that would be certainly the upper limit for any of us. You're talking about from admission to the hospital to the operating room, maybe an hour, and then in the operating room, perhaps an [p. 18] hour, and then recovery, a few hours.

So we're talking about, you know, maybe a six-hour admission to the hospital. But the procedure itself shouldn't be more than an hour.

Q. And can an induction procedure, the one you've described, can that be done outside a hospital?

A. Sure it can be, but we think it should be done within a hospital.

Q. What about a D & E? Can that be done outside a hospital?

A. It can be done in a clinic. Up to a certain gestational age, it's recommended to do it in a hospital, but it can be done in clinics and are in many instances done in clinics.

Q. Do you believe they're done fairly safely in clinics?

A. I think so, yes.

Q. Is it also fair to say then that the induction procedure at 20 weeks is going to be more expensive if it's done in a hospital as opposed to a D & E done in a clinic?

A. Yes, I would agree with that.

Q. And if you had a patient – and this is hypothetical, of course – who was 20 weeks pregnant and wanted to terminate the pregnancy, what would you [p. 19] advise her?

A. Well, what are the indications? Do I have an indication other than she doesn't want the pregnancy?

Q. She doesn't want the pregnancy.

A. I would advise her to continue the pregnancy and deliver the child and give it up for adoption. If that didn't work, then I would give her the names of physicians outside of Middle Tennessee because no one in the Middle Tennessee area would do such an abortion. And then she would have to go to another city or state or both.

Q. Do you know where, what place you would refer to?

A. We refer to Atlanta and to Louisville.

Q. Do you know what office or doctor in Atlanta you refer to?

A. No. We also would have recommended to Wichita, Kansas, and that would be Dr. George Tiller.

Q. Do you know in Georgia, is it the Midtown Hospital?

A. I believe that's the name of it.

Q. Do you know what procedure they use there? Do they use prostaglandin there?

A. The only technique I know about is Dr. [p. 20] Tiiler's. I don't know what they use in Atlanta, but it

could either be a D & E or some type of prostaglandin. I just don't know.

Q. Do you know how far in Atlanta, how far along in pregnancy they do D & E's?

A. No.

Q. Okay. Let's get back to the 20 weeks – the woman is 20 weeks. You've referred her somewhere. Would you tell her for one reason or another it's better to have a prostaglandin-induced termination or it's better to have a D & E, or would that be her choice?

A. Well, I mean if she asked me after I told her that I wouldn't do it and that there was no one in Nashville to do it and then she asked me which I would recommend, I would recommend the prostaglandin abortion rather than the D & E at 20 weeks.

Q. And what would be the basis for your recommendation?

A. Well, there are complications with both. There's no question about it. But there are fewer and fewer doctors who are really trained and are proficient at performing D and E's. It is a relatively unpalatable and unaesthetic, if those are the right words, procedure for the health care provider and those [p. 21] in the room to witness. The dismembering of a living fetus is not something to be taken lightly. The patient has to know what's going to happen, and frequently she and her significant other are not interested in a procedure that actually does that to her fetus, even though she doesn't want it. The prostaglandin technique allows for an intact delivery of a stillborn, that it may take a little longer, it may be more

expensive but doesn't have the negative connotations and doesn't include the risks of uterine perforations and significant hemorrhage that could lead to hysterectomies and has in some instances.

So I think all in all, while there are differences in morbidity and length of stay and costs, I still would recommend the prostaglandin over the D & E at 20 weeks.

Q. Can a prostaglandin induction occur when a fetus for some reason is not dead when it emerges?

A. Occasionally, a fetus at 20 weeks will be born alive. That is the heart will be beating. That is not common, but it has happened.

Q. And then can the baby survive?

A. No. Fetuses cannot survive until 23 weeks where there is a 15 percent survival rate, and that's [p. 22] why we stop at 22 weeks and 6 days at Vanderbilt.

Q. Have you ever – in the course of the procedures you've done that you indicated for some sort of fetal indication, have you ever had to decompress the head of a fetus in order to remove it?

A. Yes, I have.

Q. And what method do you use to decompress the head?

A. The procedures were though [sic] on term babies who had severe hydrocephalus, and in those cases we have used the ultrasound-guided cephalocentesis method where we drain the ventricles of the amniotic fluid to allow the head to slip through the cervix.

Q. If you saw a woman and the fetus had some sort of cranial deformity like hydrocephaly or anencephaly and the head was enlarged and she wanted to terminate the pregnancy because she believed it wasn't going to survive, the child wouldn't survive the birth, would there be any reason not to depress the skull in that situation in order to facilitate removal of the fetus?

A. Well, first of all, let's just differentiate between anencephaly and hydrocephaly. Anencephaly would never have a head so large it couldn't be delivered, and you wouldn't have to [p. 23] decompress the head because there is no brain. The top of the brain is gone, so that would never present itself with anencephaly.

But let's stay with anencephaly for a moment. If a woman came to us at 30 weeks of pregnancy or 26 weeks of pregnancy or anything beyond our normal abortion techniques of 22 weeks and 6 days and we knew that it was an anencephalic fetus, – that is it had a lethal anomaly; it could have other anomalies that would be lethal, but this would be one that we would classify as lethal – we would deliver the patient. We would induce labor, but we would not call that an abortion.

An abortion is a procedure done with the intent of delivering a dead fetus. Our intention is to deliver the fetus and if it is a lethal anomaly, it will die on its own. So we will induce that patient whenever she wants us to induce her, but we don't call it an abortion after 23 weeks. It's just an induction of labor.

Assuming we're correct in our diagnosis, then the child will die. If we're not sure that it's a lethal anomaly, then we don't offer an induction. So that then takes us to

the hydrocephalic fetus. Unless we're convinced that the hydrocephaly is so massive as [p. 24] to preclude life outside the mother's womb, regardless of the gestational age, we would only induce that labor if we were convinced that it was incompatible with life.

If we were not convinced and we used neurosurgeons to help us with this, we wouldn't offer it. But if we offered it, then we would induce the labor, and if we needed to, we would decompress the head with the cephalocentesis procedure that I mentioned to you. But our intent is not to cause death with that procedure. Our intent is to deliver the fetus which would die anyway once it was born.

Q. Tell me again some of the – the last case you're describing, exactly what instrument would you use to decompress the head?

A. We use a needle, spinal needle that's either put suprapubically or through the vagina, – usually suprapubically with a breech – and under ultrasound guidance, place the needle into the dilated ventricle and allow the fluid to be drained off.

Q. Now when you say dilated ventricle, being not a doctor, I'm thinking the heart. Can you explain what that is?

A. Sure. There are ventricles in the brain, one on the left and one on the right, that drain [p. 25] cerebral spinal fluid. And when there's a blockage, it gets backed up and causes the enlarged head, the water head babies that you've heard about. And what dilates are the ventricles

in the brain. So we put a needle into the ventricles to drain the fluid only.

We don't try to aspirate intracranial cerebral matter or brain matter. Our intention is to allow safe passage of the fetal head through the cervical canal.

Q. I might just have one or two more questions. I take it you favor the statute at issue in this case?

A. Oh, yes.

Q. And do you favor the punishment that's provided in it? Do you know what the punishment is?

A. Anywhere from what, one to twenty years in jail?

Q. Mm-hmm.

A. No. I don't favor the punishment. On the other hand, that is not my expertise. I would rather not have to have a ban on partial birth abortion because I would rather doctors be more conscientious and not offer this to women. But having said that, knowing that there are doctors who are supportive of partial birth abortion, and understanding the [p. 26] reasoning for the ban created by various state legislatures as well as our own federal government, despite the veto, I also understand that punishment has to be attached.

And this is not an area that I consider myself an expert in, but I have an opinion that I wish that we didn't have to have a felony statute with this. But it's the real world, and I accept it for reasons that we'll probably get into later.

Q. Yeah, just – and is your opposition to what you understand to be partial birth abortion based on the belief that the procedure is dangerous for women?

A. No.

Q. Is it then based on your belief that it is – well, let me see if I can –

A. I can tell you.

Q. Well, do you recall writing – excuse me. I shouldn't say writing. Do you recall saying to a reporter at the Nashville Banner something to the effect that this is a bad procedure, it's pretty gruesome, people are disgusted that doctors are even doing it?

A. Yes.

Q. So what I understand from that – tell me [p. 27] if this is right – is that you believe that it's a gruesome procedure, it's one that's needlessly harmful to a fetus and needlessly disrespectful of a fetus in some way?

A. That's one reason.

Q. What are the other reasons?

A. The other reason is it's not needed. There are safe alternatives. How safe compared to other procedures is something that we really don't know because no one has ever done any research on partial birth abortion and compared it to other procedures. So the argument that partial birth abortion described by the American College of Ob/Gyn in January of 1997 is safer has never been proven.

So it's all theory. So I think it's easy to come to the conclusion for me – and obviously many others, but certainly I'll speak for myself – that there are safe alternatives that have set some moral and ethical guidelines and works within a framework that I think is healthy for – more mentally healthy for the health care providers as well as for the patient.

So my reason is it's not needed and it is morally and ethically – it goes beyond the line that I think most of us in medicine draw between what is [p. 28] morally and ethically accepted and what is not. The two together allow me to be then supportive of a ban, even if attached to that are punishments.

Q. You mentioned there has been no study showing that this what you understand to be a partial birth abortion is safer. You would concede, wouldn't you, that if you ban the procedure, there will never be such a study?

A. Well, that will be fine with me. Sure, I understand that. You have to understand that partial birth abortion is a term that just came onto the horizon officially January of 1997. It never was in any of our textbooks in obstetrics. We were never taught it. I was never taught it. I've never seen one.

The first time I even heard of a partial birth abortion was when it was announced on the floor of the senate with posters showing the procedure. Even the term "late term abortion" has no medical meaning. It doesn't have any description in any of the literature. So this is something that some doctors have done for a variety of reasons. And we now in the medical community are being asked to comment on it so that that's what I'm doing.

Q. I understand. And don't you think such a [p. 29] ban would stifle potential advances in making abortion procedures safer for women?

A. Well, I don't think that I would call these advances.

Q. Oh, I'm sorry. I didn't say that they were advances, potential advances.

A. Well, if you have to cross an ethical line, then I don't think that even if you could prove that it may have some medical advantage that it should be used. And you have a point that if you ban a procedure, you can't do research on it. However, if the ban is well intentioned based on not only medical but in essence moral and ethical grounds, then I think you're duty bound to not even do research.

Medical research has been done on a lot of individuals and has crossed that line, and nobody I know would support the medical research that either occurred in Germany or occurs in Iraq and other places that we hear about. The fact that maybe some of that research might have brought some good to humankind later doesn't justify or rationalize the use of that research technique to find out.

So because we have safe alternatives, very safe alternatives, I think those of us who are, – speak for obstetrics, those of us who care about what people [p. 30] think, of those of us who have to do abortions in this world, I think we have a moral obligation to set certain limits and guidelines. And that's what we have done here at Vanderbilt, and that's what I continue to want to do. So I can

speak against a procedure even though many of my colleagues in Washington, for example, disagree with me.

Q. If someone found – some majority in Tennessee found that prostaglandin-induced abortions were morally offensive and banned them because there were safe alternatives, – the D & E, the partial birth procedure as you understand it – would you accept that?

A. Well, morally acceptable is obviously in the eye of the beholder so to speak, and you raise a very interesting question. If partial birth abortion is ethically and morally improper in my opinion, why not the D & E and the prostaglandin technique?

And I would agree with you if it was done beyond the stage of viability. But if it's done prior to viability, then I think these are procedures that while they would be condemned by individuals who are pro-life, I think that the fact that they are safe, that there is a need under this kind of gestational age limits that I wouldn't find it morally or ethically [p. 31] offensive.

Q. And then in terms of the partial birth procedure you're talking about, how do you define that?

A. Well, I define it as the American College defined it. There were four criteria: Intentional dilatation of the cervix, converting a fetus to a breech, extracting to the head, and then evacuating the intracranial contents. That is the American College of Ob/Gyn's definition. The definition that has surfaced in Nebraska as well as Tennessee is different.

Q. But you believe covers the exact same procedure?

A. Well, I'm not wild about the wording, and I would love to have had the American College of Ob/Gyn's definition used, but I understand the reasons or I believe I understand the reasons why it was not. But I think it is specific enough to include the American College of Ob/Gyn's definition.

Q. For example, does it include anything about conversion of the fetus?

A. No.

Q. So it doesn't match in that respect?

A. No. Actually one and two, the first two definitions really are not very important to the procedure because if the fetus is already breech, then [p. 32] the doctor wouldn't have to convert. But the third and fourth definitions, – that is delivery to the fetal head and then evacuation of the intracranial contents – I think those two are covered by the statute that Nebraska and Tennessee have written into their law.

Q. What was the first of those two that you think is covered again, please?

A. Delivery of the fetus to its neck.

Q. Where do you see that? How do you get that in the Nebraska statute?

A. Oh, not in the Nebraska. In the American College of Ob/Gyn.

Q. But is it in the Nebraska statute?

A. No, but I think the Nebraska statute is specific enough to include either the four or the two definitions that I just described from the college.

Q. I'm sorry. This will hopefully cut down on my eventual cross-examination.

A. Okay.

Q. You indicated that you had observed or assisted in a D & E within the last –

A. Three or four years.

Q. When was the last time you actually performed one, yourself?

[p. 33] A. Maybe ten years.

Q. Now in a D & E, can you sometimes reach into the uterus with forceps, remove let's say a hand?

A. Yes.

Q. Can the fetus still be alive?

A. Yes.

Q. Is a hand a substantial portion of the fetus?

A. That will eventually obviously be the pivotal point if it ever gets to someone trying to push the issue for definition. In my opinion the word "substantial" does not include a hand.

Q. And what's your basis?

A. Well, substantial means a significant portion.I think a significant portion is not a hand.

Q. Would it be a leg?

A. No. I think you'd have to bring in a reasonably large portion of the fetus through the birth canal. And I'm not sure that I can define that, but I don't think anyone has or could. So I think that's where some people have been concerned.

I feel substantial portion means a significant portion of the fetus. And while I could say greater than half of the body, that would be my own personal view and not necessarily the view of someone [p. 34] who wants to prosecute this letter of the law.

Q. So you would agree that some people might view removal of a hand as a substantial portion. Certainly if –

A. Well, in this country I suppose anything could be said. But I think that the average jury would not believe a hand to be a substantial portion. Having said that, I hope it's never tested. But the easiest way to get around this whole thing is for doctors to stop doing this procedure.

Q. I understand. But if it did cover – if a hand did constitute a substantial portion or a leg, you would agree the statute could cover D & E's?

A. If that were deemed a legal definition then, of course, it would include D & E's.

Q. Have you seen any legal definition more carefully defining "substantial portion" than Nebraska law?

A. No, I haven't. The other states, for example, that don't have this added definition that the AMA's bill or rule allowed, which is what Nebraska copied or used as

their definition, without that particular wording – that is delivering a living fetus into the vagina or a substantial portion – without that, then D & E's would be included, any D & E [p. 35] would be included in the definition.

Q. Why is that?

A. Because I think if you don't have the word "substantial", then a hand or a foot would be considered under the definition as the states have written them.

MR. HELLER: Thank you.

(Deposition ended at 11:24 a.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 33

Nebraska State Legislature
[LOGO]
Ninety-Fifth Legislature

[Names And Addresses Omitted In Printing]

MEMORANDUM

To: Co-Sponsors of LB 23

From: Senator David I. Maurstad

Date: April 10, 1997

Re: Preliminary Information on Partial-Birth Abortion

As we work down the list of Senator Priority Bills on general file, LB 23 has moved closer to the top of the agenda. After consulting with the Speaker's Office it is difficult to determine how soon the bill will be addressed. However, should LB 23 be debated in the near future, I wanted you and other co-sponsors to have some preliminary information about the issue.

I also want to take this opportunity to make a personal plea for your presence on the floor during discussion of this bill. Your presence and support would be appreciated, especially on key votes.

Attached is material prepared by my office in cooperation with Julie Schmit-Albin and Jim Cunningham. We have attempted to address questions that have been raised

about the partial-birth abortion issue. I will have additional information which will be distributed on the floor when the bill is taken up.

If you have any questions about LB 23 or the partial-birth abortion issue, please do not hesitate to let me know. I will do my best to provide you with whatever information you need.

PARTIAL BIRTH ABORTION: A FACT SHEET

What is a Partial-Birth Abortion and What Would LB 23 Do?

- LB 23, as amended by committee amendment (AM0748), defines partial-birth abortion as an "abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."
- LB 23 would prohibit performance of any partial birth abortion, except in cases (if there are any) in which the procedure is necessary to save the life of a mother and no other procedure would suffice.
- Abortionists who violate the law would be subject to both criminal and civil penalties, but no penalty could be applied to the woman who obtained such an abortion.

Are the Drawings and Descriptions Accurate?

YES, absolutely! The drawings and descriptions of the partial-birth abortion procedure (see attachment #1) are based upon a 1992 paper presented to the National Abortion Federation by Ohio Abortionist Martin Haskell in which he described in detail, step-by-step, how to perform the procedure. Dr. Haskell has acknowledged

that these drawings are "technically accurate." (*American Medical News*, 7/5/93) The following description came from his paper:

- "With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. The skull lodges at the internal cervical os [the opening to the uterus]. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up. At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down) . . . [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger . . . [T]he surgeon then forces the scissors into the base of the skull or into the formen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents."

Partial-Birth, D & X, Intact D & E – Which Term Should Be Used?

- There is no consensus even among abortion practitioners, about what to call this procedure. One doctor calls it "dilation and extraction" ("D & X"), and another "intact dilation and evacuation" ("intact D & E"). When the Partial-Birth Abortion Ban Act was written in 1995, neither "D & X" nor "intact D & E" appeared in any medical dictionary or in the Medline medical database. Nor did either term appear in the

textbook on abortion methods, *Abortion Practice*, by late-term abortion specialist Dr. Warren Hern.

- Thus, these terms ("D&X", "Intact D&E") originated as a kind of pseudo-medical jargon which should not be employed in a criminal law because of the risk that the courts will declare that law to be "void for vagueness." "Partial-birth abortion" was chosen to satisfy the requirement that criminal laws must be precisely descriptive of what is forbidden in order to pass constitutional muster.

Why are Partial-Birth Abortions Performed?

- *The overwhelming majority of partial-birth abortions are performed for purely non-medical reasons.*
- Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, while admitting to lying previously about this, confirmed in the March 3, 1997 *American Medical News*, that in the vast majority of cases the procedure is performed on a healthy mother with a healthy fetus of 20 weeks or more gestation.
- On September 15, the Bergen, N.J. *Record* published a report by staff writer Ruth Padawer in which two abortionists at an abortion facility in Engelwood, N.J. admitted performing over 1,500 partial-birth abortions. The following are the reasons they stated for performing these procedures:

"We have an occasional amnio abnormality, but it's a minuscule amount." Most are Medicaid patients, black and white, and most are for elective, not medical, reasons: people who didn't realize, or didn't care, how far along they were. Most are teenagers."

- The September 17, 1996 edition of the *Washington Post* contained the results of an investigation conducted by

reporters Barbara Vobejda and David Brown, M.D., who interviewed several doctors (*not* those in New Jersey), and concluded:

"Furthermore, in most cases where the procedure is used, the physical health of the woman whose pregnancy is being terminated is not in jeopardy . . . Instead, the "typical" patients tend to be young, low-income women, often poorly educated or naive, whose reasons for waiting so long to end their pregnancies are rarely medical."

- In a taped interview for the American Medical Association's *American Medical News* (July 5, 1993), Dr. Martin Haskell said of partial-birth abortions he performs:

"And I'll be quite frank: most of my abortions are elective in that 20-24 week range . . . In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective."

- Before his death in 1995, Dr. James McMahon voluntarily submitted to the House Judiciary Subcommittee on the Constitution a self-selected sample of more than 2000 partial-birth abortions he performed and the reason for each.

Only 175 of these procedures were done for "maternal indications," the most common of which was "depression." 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders such as cleft palate and Down Syndrome. More than one-third of these 2000 cases did not involve either fetal or maternal health problems, however trivial.

- In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws"

group. She concluded that "most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting."

At What Stage of Pregnancy Are Partial-Birth Abortions Performed?

- Apparently, **most partial-birth abortions are performed late in the second trimester, between 16 and 24 weeks' gestation.** However, **some are performed in the third trimester** and not only for cases of extreme physical disorders of the mother and/or baby as claimed by abortion advocates.
- In 1995, the late Dr. James McMahon submitted to the House Judiciary Subcommittee on the Constitution a graph and explanation that explicitly showed that **he aborted *healthy* ("not flawed") babies** *even in the third trimester (after 26 weeks of pregnancy)*. Dr. McMahon's own graph showed, for example, that at 29 or 30 weeks, *one-fourth* of the aborted babies had no "flaw" however slight.

How Many Partial-Birth Abortions are Performed?

- Partial-birth abortions occur at least several thousand times a year in the United States. Just one New Jersey facility reported performing about 1500 each year. Ron Fitzsimmons from the National Coalition of Abortion Providers, recently publicly acknowledged that there are **as many as 5000 per year in the United States.**
- **Leroy Carhart, a Bellevue abortionist, admitted in an *American Medical News* article (10/7/96) to performing 1000 "intact D and E's" in the last two years.**

Partial-Birth Abortions – Nebraska Connection

According to an October 7, 1996 *American Medical News* article, Leroy Carhart, a Bellevue abortionist, "has done about 5000 intact D & E's [dilation and evacuation/partial-birth abortions] and 500 in the last year." Diane Gianelli, who wrote the article, sent a copy of it to Carhart after it was printed and received no response regarding its accuracy.

In a subsequent *AM News* article regarding the Ron Fitzsimmons' lie, Gianelli again mentioned Carhart's admission to doing "about 5000 intact D & E's, about a 1000 during the past two years". Then, in the February 28, 1997 *Omaha World Herald*, Carhart claims that the *AM News* article was inaccurate and that what he meant to say was that he had performed about 5000 abortions in 1994 and 1995, of which 1000 were second trimester and about 50 to 100 were by "intact D & E".

Diane Gianelli, who conducted and taped the interview, contacted Carhart and played to him the tape of the interview. Since the tape makes it quite clear that Carhart performed 1000 "intact D & E's" in the last two years, he then acknowledged that the original article was accurate, but now says what he meant to say was that he performed 1000 late term abortions in the last two years in which he attempted to use the "intact D & E" (partial-birth abortion) method. However, he claims, the babies fell apart as he tried to pull them from the womb causing him to complete the abortion with a different procedure. Carhart says he kills the child with a lethal injection prior to performing the partial-birth abortion procedure.

[See Attachment #2 for related articles/documents on Leroy Carhart]

MOTHER'S HEALTH AND FUTURE FERTILITY ARGUMENT A FALLACY

Opponents of a ban on partial-birth abortions rely most heavily upon the widely publicized accounts of a few women whose doctor (the late James McMahon) told them that their children were gravely ill and that a partial-birth abortion was necessary to preserve their health or future fertility.

- **Nearly 500 doctors (more than 50 from Nebraska), mostly obstetricians/gynecologists and fetal/maternal experts, under the banner of the Physicians' Ad-Hoc Coalition for Truth, along with former Surgeon General Koop have publicly verified that *there are no medical conditions*, either maternal or fetal, that necessitate the use of partial-birth abortion in order to preserve the mother's health or future fertility. (See attachment # 3 for a list of Nebraska members of PHACT)**

Pamela Smith, M.D., Ob/Gyn, currently Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago; an Assistant Professor at the Finch University/Chicago Medical School; and a member of the American College of Obstetricians and Gynecologists, stated in testimony before the U.S. Senate Judiciary Committee on November 17, 1995:

- **"In short, there are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life or health of the mother."**

Curtis R. Cook, M.D., Maternal Fetal Medicine, Butterworth Hospital, Michigan State College of Human Medicine, stated in testimony before a March 11, 1997 House/Senate committee hearing:

- **"There is no record of these procedures in any medical text, journals, or on-line medical services. There is no known quality assurance, credentialling, or other standard assessment usually associated with newly-described surgical techniques. Neither the Centers for Disease Control nor the Alan Guttmacher Institute have any data on partial-birth abortion, and certainly no basis upon which to state the claim that [partial-birth abortion] is safer or even a preferred procedure."**

Even Some Abortionists Challenge the Medical Necessity Claim

In testimony in an Ohio lawsuit concerning the banning of partial-birth abortions, Dr. Harlan Giles, who performs second trimester abortions up to the point of viability, testified:

- **"I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that, also, require that the fetus be dead or that the fetal life be terminated. In my experience for twenty years, one can deliver these fetuses either vaginally or by caesarean section for that matter depending on the choice of the parent . . . And I cannot think of a fetal condition or malformation, no matter how severe, that actually cases [sic] harm or risk to the mother of continuing the pregnancy." (*Woman's Medical Professional Corp. v. Voinovich*, No.C-3-95-414, U.S. District Court, Southern District, Ohio (1995)).**

Dr. Warren Hern, a late-term abortion specialist who wrote a textbook on abortion methods, *Abortion Practice*, said in an 11/20/95 article in the *American Medical News:*

- **"I would dispute any claim that this [partial-birth abortion] is the safest procedure to use."**

Partial-Birth Abortion Poses a Threat to Women's Health and Fertility

Paul Hayes, M.D., a practicing Ob/Gyn in Lincoln and fellow in the American College of Obstetricians and Gynecologists, stated in testimony before the Legislature's Judiciary Committee (2/12/97):

- **"I think it's important to realize what this procedure asks of us as doctors to do . . . possibly as many as three very, very risky procedures. One is the dilation of the cervix itself manually before it is time for that to occur on its own and that runs a woman's risk up for preterm labor in the future. Also the instrumentation, putting sharp instruments into a woman's uterus blindly runs the risk of uterine perforation. And the very procedure of reaching into a woman's uterus, turning the baby from a head first position to a feet first position is literally prescribed against by my college of obstetricians and gynecologists, is forbidden by the *Williams Obstetrics and Gynecology* textbook as being entirely too risky for many different medical complications that occur . . . "**

So Who's Right About Partial-Birth Abortion's Impact on Woman's Health?

- *Look at the evidence*!!! Nationally, nearly 500 obstetricians/gynecologists, fetal-maternal medicine specialists, family practitioners, pediatricians, and other physicians (including former U.S. surgeon general C. Everett Koop, professors and hospital department heads) have publicly verified that partial-birth abortion is never medically indicated nor preferable, and, is itself a risk to the woman's life, health, and future fertility.

- We know of only one doctor nationally *not* affiliated with the abortion industry who has publicly defended the procedure as preferable to other late-term methods. It is likewise instructive that no physician testified in opposition to LB 23 at the public hearing held by the Judiciary Committee. Conversely, two physicians who specialize in obstetrics and gynecology, and who have significant experience treating pregnant women with difficult pregnancies like those used to defend partial-birth abortion, testified that this procedure is *never* necessary to preserve a mother's health or future fertility and, in fact, is quite dangerous to the mother.

- Even the American College of Obstetricians and Gynecologists (ACOG), a pro-abortion organization, has issued this statement: "A select panel convened by ACOG could identify no circumstances under which *this* procedure would be the only option to save the life or preserve the health of the women." Then citing neither specifics nor documentation, ACOG added that the procedure "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor . . . can make this decision." Members of PHACT, many of whom are members of ACOG, noted that ACOG had violated its own standards by approving a procedure for which there exists no peer-reviewed or safety data.

- In an interview with *American Medical News*, ACOG President, Frederic D. Frigoletto, M.D., backed away from the published statement. He claimed that ACOG

had not endorsed the procedure, and admitted that "there are no data to say that one of the procedures is safer than the other." It may be the best in some cases, he said, *"or it may not be."*

- The AMA Legislative Council unanimously rejected partial-birth abortion, saying it is "basically repulsive" and the AMA thereupon took no position on the proposed ban.

Why Use This Method?

In a partial-birth abortion, the abortionist dilates a woman's cervix for three days, until it is open enough to deliver the entire baby breech, except for the head.

- In a taped interview with *American Medical News* (July 5, 1993) Dr. Martin Haskell conceded that with a little further dilation, the **"fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead."**

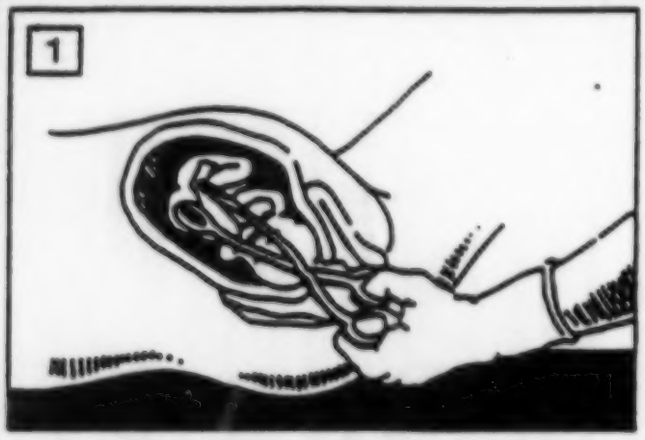
Is a Ban on Partial-Birth Abortion Constitutional?

- *Roe v. Wade,* which defined an expansive "right" to abortion, explicitly stated that its ruling did not apply to the killing of a child in the process of being born. [attachment #4] The partial-birth procedure is essentially the same as the procedure for inducing a breech birth, except that the child is killed when already mostly delivered. Even pro-abortion legal experts like Lawrence Tribe of Harvard University have said that the Supreme Court might uphold a ban on this kind of infanticide.

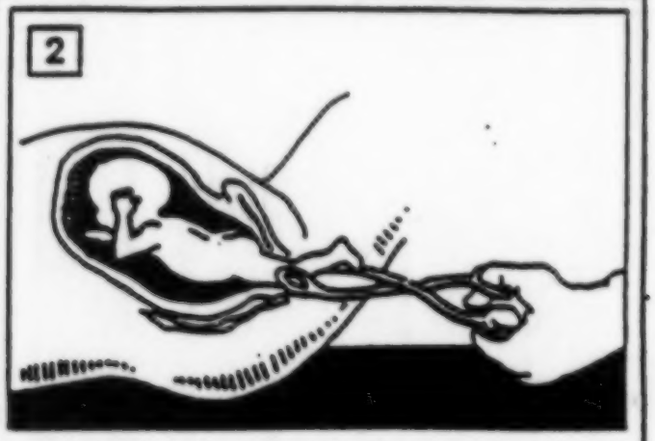
- In Nebraska, Attorney General Don Stenberg issued an official opinion in May 1996 concluding that a ban on partial-birth abortion could withstand constitutional challenge if enacted by the Nebraska Legislature. [attachment #5]

ATTACHMENT #1

PARTIAL-BIRTH ABORTION

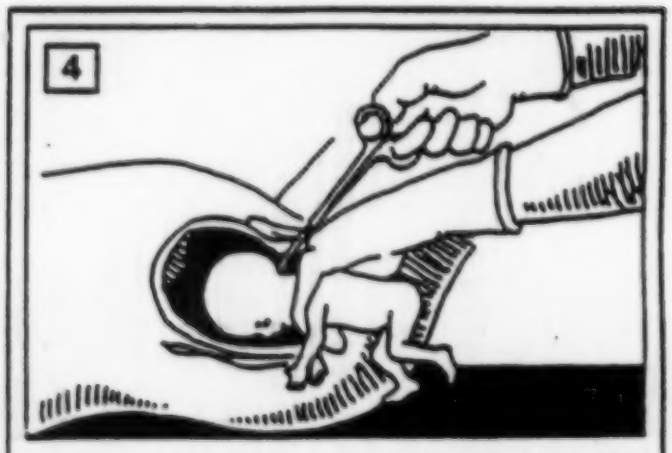


Guided by ultrasound, the abortionist grabs the baby's leg with forceps.

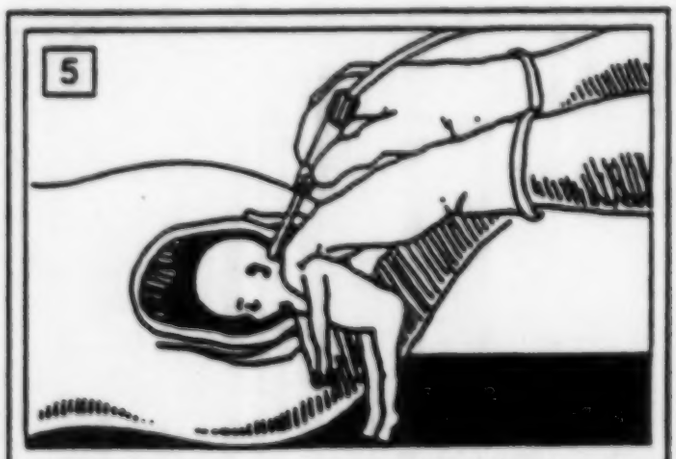


The baby's leg is pulled out into the birth canal.

The abortionist delivers the baby's entire body, except for the head.



The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

Judiciary Committee Memorandum
April 11, 1997

Proponents and opponents look at different aspects of constitutional abortion law in determining the constitutionality of partial-birth abortion statutes.

ARGUMENTS FOR CONSTITUTIONALITY

1. It can be argued that a child that is **partially born** obtains constitutional "person-hood" upon emerging from the birth canal even if not yet fully delivered and therefore the state has a constitutionally valid interest in preventing the killing of such child, which, under the definition, does not take place until **after** the child is partially delivered.

   The U.S. Supreme Court has not directly ruled on this issue, but **some weight** can be given the fact that *Roe v. Wade* did not challenge a provision in the Texas criminal code that made it a crime to kill a child "in a state of being born and before actual birth." Such statute remains on the books in Texas.

   The Supreme Court in *Roe* simply mentions that such section is the only section in the code chapter on abortion that is not being challenged as unconstitutional in that case. It is a **stretch** to state, as the House Judiciary Committee does, that such footnote "distinguishes between a child who is 'unborn' and 'being born.' "

   All that can be said for certain is that *Roe* did not strike down that particular section of the Texas criminal code, but, since it was not challenged, it would have been overreaching for the Court to do so.

Accordingly, this argument is **rather speculative** at this juncture. It certainly has merit, but there is no specific Supreme Court precedent upon which to rely.

To support the constitutionality of LB 23, the following argument would have to be upheld by the court: the state has a valid interest in protecting the life of a partially born child that is greater than its interest in protecting the life of a completely unborn child; therefore, the state may enact restrictions that protect the life of the **partially born child** after viability **without an exception as to the preservation of the health of the mother** and may enact restrictions that protect the life of the partially born child before viability even though such restrictions place an **undue burden** on the mother's right to an abortion.

2. The second argument is based on *Planned Parenthood v. Casey*, the most recent Supreme Court abortion decision. It contends that, even if the Court does not recognize a different constitutional status for the partially born, the banning of **partial-birth** procedures does not impose an **"undue burden"** on the right to choose an abortion.

   Under *Casey*, the state can act to "regulate" abortion **at any stage of a pregnancy** so long as the regulation does not place an **"undue burden"** on the right to choose an abortion. Accordingly, if a regulation does not place an undue burden on the abortion right, there is no need to consider whether the baby is "viable" nor whether there must be a "health" exception. (Regulations that do place an undue burden on the right can only apply after viability and still must contain exceptions for the "preservation of the life or health of the mother.")

   The validity of the "no undue burden" argument depends on the **factual determination** as to the use of partial-birth procedures.

I believe that this burden can be met, but a factual record needs to be made in accordance with the following:

- The purpose of the bill is to ban **one particular type of technique** (I call it a "type of technique" because the doctors who use the technique describe it by differing names and may use different means; the definition describes particular steps that are entailed in a "partial-birth" abortion) of accomplishing abortion.
- That particular type of technique, unlike alternatives, is particularly **akin to** acts that are **already criminalized**, is particularly contrary to state's legitimate and already expressed interest in the **protection of life** and is particularly shocking to the community's **sense of acceptable behavior**.
- The intent of the bill is **not to prohibit** any alternative techniques of accomplishing abortion.
- The effect of the bill is to **allow all other abortion techniques** to continue uninterrupted.
- The right to abortion **existed and was not unduly burdened** before the partial-birth type of technique was developed (it is not entirely clear when Dr. Haskell started using his version of partial-birth technique, but it was sometime between 1979 and 1992; *Roe* was decided in 1974).
- The right to abortion **exists and is not unduly burdened** in areas where doctors do not employ partial-birth type techniques (it is generally acknowledged that not all abortionists use such).
- The doctors who developed partial-birth techniques **did not develop such** in order to **protect the health or life** of their patients. Dr. Haskell frankly stated that he developed the technique

because it was **faster** and **less expensive** than alternative techniques (and, by allowing him to perform more late-term abortions, allowed him to make more money).

- The **tremendous weight** of **reliable medical opinion** is that partial-birth techniques are **never the only safe technique available** and **never medically necessary to save the life or health of the mother.**

Accordingly, I believe that a factual case can be made that "no substantial obstacle" is placed before a woman's right to choose an abortion by the banning of partial-birth type techniques. There would never be a case in which an abortion could not be performed.

ARGUMENTS AGAINST CONSTITUTIONALITY

1. Opponents argue first that a partial-birth abortion ban would be **unconstitutionally vague** regardless of its status under constitutional abortion law. When imposing a criminal sanction, the Legislature has a constitutional duty to clearly inform the public what acts are prohibited.

   Opponents contend that because the definition refers to "partial-birth abortion" and not a medically recognized term, that a doctor is not informed as to the exact technique that is criminalized.

   In response, it is evident from the medical literature that there are **a number** of terms that are used to describe techniques involving partial birth and that **none** is a universally acknowledged term.

   Instead, "partial-birth" is a **descriptive term** that covers **any technique**, regardless of the name used by the

given doctor, that involves the elements described in the bill.

I agree that a different term would be appropriate, such as "abortions involving the partial delivery of a living child." Right to Life insists on the term "partial-birth." Nonetheless, I think the elements of the offense are very clear and not vague:

- Partial vaginal delivery of a living unborn child.
- Killing the child; and
- Completing the delivery.

2. Opponents also point to the lack of a **health exception**. Clearly, under *Casey*, any prohibition of abortion can only apply (1) after viability and (2) contain a life and health of the mother exception.

   Since LB 23 applies to both pre- and post-viability abortions, the issue of a health exception is **irrelevant** because **any** restriction that places an "undue burden" on the abortion choice prior to viability is unconstitutional (whether it has a health exception or not) and any restriction that **does not** place an "undue burden" is constitutional **both before and after viability** (again, regardless of whether it has a health exception).

   Opponents confuse the prohibition of **abortion** (period) and prohibition of a **type of abortion**.

   - Clearly, the state cannot prevent a woman from **having an abortion** until after viability and only if it allows life and health exceptions.
   - If the state intends to prohibit a woman from **having a particular type of abortion**, then it must be determined whether the purpose or effect is to place an undue burden on the abortion right.

- If it **does** place an undue burden, then it cannot be imposed **prior to viability.**
- If it **does** place an undue burden, then it can be imposed **after viability** but only with life and health **exceptions**.
- If it **does not** place an undue burden, then it can be imposed before or after viability and with or without life and health exceptions.

If LB 23 were relying on the post-viability aspects of *Casey*, then it could only apply after viability and would have to include a health exception. Since LB 23 by its terms does **not** only apply after viability, its constitutionality **cannot** rely on the post-viability language of *Casey*. Therefore, it **must** base its constitutionality on the "undue burden" language of *Casey* **or** the argument that a partially born child has a different constitutional status than a completely unborn one.

The only way, then, that a health exception would be relevant to the legal analysis is if it were relevant to the "undue burden" determination. That is, theoretically, a regulation could constitute an "undue burden" if it lacks a health exception and not constitute an "undue burden" if it has a health exception. However, **if LB 23 does not constitute an "undue burden" as written,** then a health exception is irrelevant.